State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 10:32p M BERNICE JAMES 13 2008 HORTENSE MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HAVRE DE GRACE HARFORD CO. CITIZENS NURSING & REHAB If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR. 19 1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours Months Days 1⊠M 2□ F MARYLAND Director 220-22-0812 85 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State show Examiner must be notified at 1 ☐ Yes 2 XNo Director HAVRE DE GRACE MARYLAND HARFORD CO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 21078 U.S.A. 415 S. MARKET STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2XXIo Specify: Specify: BLACK Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic avant, the Medical 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 should be filed with and Mental Hygien 7 Is marked other th HOUSEWIFE 12th grade 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) bermit Pages 1 and 2 should be.
Department of Health and Mental P.
Important: If item 27 is more any injury or other Be GENEVA BARNES 2 ERNEST B. WAINWRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Elizabeth St., Havre De Grace, Md., 21078 Althea James/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial ↑ □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) HAVRE DE GRACE, MARYLAND ST. JAMES CEMETERY 05-17-08 21. Signal & of Funeral Service Licens 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.
321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 roun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rena Immediate Cause (Final **Physician** mrs. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a ry, isaging to limit solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Box 68760. the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) page 2 should be detached o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other ajgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Clevease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 XNo 1 ☐ Yes the Hospital or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vinursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Tes 2 No investigation within 24 hours after death. To the Funeral Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier dugnino D-15994 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. HAURE DE GRACE S. UNION Leticia S. Galvez 625 12,0-32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar more It sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** aisc CICKSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner on Selvers Torrere Under 1 Year 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year Months Days Min 1 □ M 2 **X** F 218-18-4595 Usual Residence of Decedent Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he martitled as 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 MYes 2 □ No Ma. Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? H 21216 rove Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) de Vorker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) )0rm Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 Other (Specify) Entombment 22. Name and Address of Facility Joseph L. Russ Fun 2222 W. North Ave. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part / Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediale Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an funeral director, page 2: NSCOS 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Urector: A 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of pers with completed cause of 2000 th (Item 23a) (Type, Print)

State Registrar Margarita (31. Date filed (Month, Day, Year)

			State of Maryland / Dep			al Hygie	ene	
	_		Registrar	rtificate of Death			. No. 2	16503
г	Physicia	an	1. Decedent's Name (First, Middle, Last)		M	ate of Death lonth	Day Year	3. Time of Death
	/Medic	al	Mary Ellen Kallay	T 41 00 T		y 19,	2008	12:30 P <sup>M</sup>
)	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death		4c. County of Dea	tn
-			833 W. Pratt Street Apt. 314  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year   If Under	r 24 Hrs.   8. Da	ate of Birth	N/A 9. Bir	thplace (State or Foreign
	Funeral Director		216–32–1369 <sup>1 M</sup> X F 71 Yrs.	Months Days Hours	Min. 07	7/30/19	936 Mar	yland
	manual side		Usual Residence of Decedent					
	rylan how lat		10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	cto	Maryland N/A Baltimore					
	or 2	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What Co	ountry?
	ath w		833 W. Pratt Street Apt 314	21201			Inited Sta	
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No.	Was Decedent of Hispanic On If Yes, specify Cuban, Mexica	rigin? (Specify Y an, Puerto Rican	es or No- , etc.)	14. Race - Ame Black, Whi	
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 3 □ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 No Specify	<b>/</b> :		Specify: Wh	nite
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<u>Ja</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. I and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	은	Frank Gantt	Unkı	nown			
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0	Pages 1 nent of H int: If Iter iry or oth		1 🗆 Buriai 2 🗓 Cremation 3 🗆 Hemoval from State	ematory or other place)	Date	ļ	c. Location - City or	
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		11.	23a. Part1 Enter the disease, or complications that caused the death. Do not en	01 S. Chester				Approximate
			snock, or heart failure. List only one cause on each line.	Λ			,	Interval Between Onset and Death
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<u> </u>	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part	11. 2	23e. Did toba	cco use contribute t	o the cause of death?
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	S	To B	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	nt 3 DOA Other: 4 N	Nursing Home	5 PAesiden	ce 6 ⊟Other (Spe	ecify)
Division or	ding Pr h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) 1 Injury	of 28c. Injury at Work?	28d. D	Describe how	injury occurred	
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$\geq$	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Lo	ocation (Stre Sity or Town,	et and Number or F State)	ural Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only one)    Check only one)					
	To the vithin 2 To the complete	Me	29b. Signature and title of certifier	29c. License number		290	I. Date signed (Mon	th, Day, Year)
)			Tuin X Line MD	DULLA	5		5.21.0	8
•	_		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	^			
	2		FRANCIS X-SAVAIN, ICT, MI	501 ST 1	PAUL	SA	W M	D ZIZOZ
	Sta	te ar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	de d				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** AM 404 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randalls North WEST Hos TOW If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 18 M 2□F Months Days Hours 215408318 65 Director 0003476, 1942 MARYLAND Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 28a-f show 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2111 ROAD CEDARMEDE JS.A Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 2⊠No Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION ARPENTER 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDWARD ပ ころくららく 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21117 JACOB RUDASILI 1DAULUTER CEDARMENE OWING MILLS 16 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) ANATOMY LIFTS NELISTRY MAY 21, 2008 HANOVED 22. Name and Address of Facility

ANATOMY LIFTS NEWSTRY 21. Signature of Funeral Service Licensee any In 95.016 CM. MANCHAN BUING YAMBAHOU EE 36 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ulmonaly **Physician** /Medical Due to (or as a consequence of) **Examiner** ひフ Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Junkhown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 201NO ၀ 1 Hipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65843 May, 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road, Randallstown, MD 21133

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AY 2 1 2008 See & Spell

08-03730 Darik

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2008 16505

Darik Anwar Leigh		St. For State	ate of Maryl	and / D	eparl <i>Certi</i>	tment of ificate of	Health Death	and	Mental		Reg.	No	a. U		
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Director		17-96-9099	1X M 2 F	<u> </u>		27 Yrs.			L		<u> </u>				
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72 h	ete	Elementary/Secondary (0-12	colleg	e (1-4 or 5+	')	TINIEN	MPLOY	רח					N/A		
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21 be fi ental rrked	Be	EVANS ANWAR	LEIGH			19b. Mailir	ng Address	(Stree	t and Numb	er or Rural	Route Numb	er, City or	Town, St	tate, Zip Code)	
21 nould Me is ma	P	9a. Informant's Name/Relatio									on, N	C. 2	8326		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	L	Lonnie E. Hur	mphrey/Br	other		Place of Dispo	sition (Nar	ne of cer	metery,	Da	ate	20c. Loca	tion - City	y or Town, State	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	ı	21. Signature of Funeral Servi	ce Licensee			22. W	Name and ILLIA	M C	BROWN	COM	4 FUNE	RAL H	OME-	HARFORD,	, P.A.
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> Physician		23a. Part I. Enter the disease, failure. List only one cau	or complications the	nat caused t	the death	h. Do not enter	the mode	os ayırıg	, such as cu						Onset and eath
√ Medical		Immediate Cause (Final disea	ase a. Head a												
aminer		or condition resulting in death	Due to (or	as a conse	quence	of):									
		Sequentially list conditions,	b			-6).									
	ner	if any, leading to immediate cause. Enter Underlying Cau		as a conse	equence	OT):									
	اعً ا	(Disease or injury that initiate	ed	r as a conse	equence	of):									
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xecuted n and l - transit	<u>a</u>	UNPENDED	AMENI	DED											
O, be existin	ed i		23c If	yes, outcor	me of pre	egnancy							Date of de		Voor
Box 68760 e death certificate b the attending physi cd for use as the bh	siclan/Me	IF FEMALE: 23b. Was decedent pregnant		Live birth		2	Fetal deat	h 3	Ectopic	c pregnanc	У	Mo	onth	Day	Year
r 68 certi endin use a	cial	past 12 months?		Pregnant at	time of	death 5	Other (Sp	ecify)							
30x death	ysi	1 Yes 2 No 9		Unknown					aires in Pr	art I	23e. Did t	obacco use	e contribu	ute to the cause	of death?
D. Ent the	Phy	Part II. Dther significant co	nditions contribu	iting to deat	th but no	it resulting in th	ne underlyl	ng cause	e given in Fa	art i.				Probably 4	
ords, P.O. Bo w requires that the de as been signed by the g should be detached f	ğ										24a. Was		24h We	ere autonsy findii	nas available
ds, equir een s	Completed										auto	psy	ргі	ior to completion eath?	of cause of
OC law r law r bas b 2 sh											1 ✓ Yes	ormed?			2 No
Rec The The grate	- E							26.Pla	ace of Death	(Check or	nly one)				
ian: ian: certifi	Be	25. Was case referred to me examiner?	edical Hospital:	4 Inneti	ient 2	ER/Outpat	tient 3	DOA	Other <sub>4</sub>		Home 5	Residence	ce 6 🗸	Other: Scene	
of Vital Records, ing Physician: The law requir After this certificate has been s	2	1 ✔ Yes 2 No		. Date of In		28b. Time		-ē	njury at Wor	k? 2	28d. Describe	e how injury	y occurre	ed and in collision	
Of Of After	ڃَ ا	27. Manner of Death  1 Natural 5	F	(Month, Oay,	Year)	FOUND		1	Yes 2 ₩		assenger	r of auto	INVDIVE	ed in collision	'
ion tendi tor:	랿	1 Natural 5 2 ✓ Accident	Pending [ M	ay 16 200	18	0224 hrs At home, farm,	street fact	ony offic			28f. Location	(Street and	d Numbe	er or Rural Route	Number, Cit
Division tal or Attendi urs after death.	ij.	3 Suicide 6	Could not be 28				Street, ract	ory, ome	C Danamy,					or Way, Roseda	
	Certification:	4 Homicide		pecify) L					lle/ -		due to the co	uco(e) and	manner	as stated.	
Hosp 24 ho Fune	,	29a. Certifier 1 Certify	ing Physician: To	the best of	my know	vledge, death o	occurred at	the time my onir	e, date and p nion, death o	place, and o occurred at	the time, da	te and plac	e, and du	ue to the cause(s	·)
To the Hosp within 24 ho To the Fund	Medical			e basis of ex anner state	d.	on and/or mives	T	20- 11-	ense numbe	er .		29d. D	ate signe	ed (Month, Day,)	Year)
£ 3 £ 5	Z Z	29b. Signature and title of	certifier	110						<b>51</b>		- 1	16, 20		
			1/	1				O.	.C.M.E.			Ividy	. 5, 25		
1		30. Name and address of p	erson who comple	ted cause o	f death (	Item 23a)					004				
1 6		Jack Titus MD.	Deputy Chief	Medical	Exami	iner 111	Penn S	treet, E	3altimore	, MD 21	201				
	Ctat	Di Di Glad (Marath Day	Year)	3. Regis	trar's Sig	gnature									
	Stat		1 2008	Water.	J 2	K do	and a								

ORIGINAL

# LOVICK, RUDY L.

. Box 68760,
P.0
Records,
of Vital
Division c

				or Print in Black e of Maryland / D				-	_	ble.		
			State Registrar		Certifica	ate of L	Death	Reg	j. No. 🥭 📒	100	, 6000	
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day	Year	3. Time of Death	
	/Medic		RUDY L. LOVICK					May		008	12:54 P M	
	Examin	er	4a. Facility Name (If not institution, give street and Greater Baltimore Med		4b. Ci		Location of Death		4c. County of Death  Baltimore			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birt		der 1 Year	WSON If Under 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign	
	Director		208-05-9927 1XXM 2 Usual Residence of Decedent		rrs. Monti	ns Days	Hours Min.	Aug 11,1	913		nŝylvania	
	Marylan -f show fed at	tor	10a. State 10b. County  Maryland None	10c. City, Town							10d. Inside City Limits  10d. Inside City Limits  10d. Inside City Limits	
	h the	Directo	10e. Street and Number		10f.	Zip Code		10	g. Citizen of		ntry?	
	23a c	ral	1012 East Lake Avenue			21212				JSA		
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ent, the Macked Examiner must be muffled at	by Funeral	1 Never Married AMMarried 11.	Decedent Ever in U.S. d Forces? ′es 2  No  WWII ,, Give or Dates:		cedent of Hi pecify Cuba 2XXNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. ite	
215-0036	hin 72 hou e. an "natura Macheel E	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Sepondary (0-12) Colle		Decedent's U (Give kind of life. DO NO	work done d Fuse retired	luring most of work )	ing	6b. Kind of B			
2121	e filed wil al Hygien other th vent, the		11			Age		(First Middle Ad		suran	ce	
$\subseteq$	ev d	To Be	17. Father's Name (First, Middle, Last)  John Lovick				Mary S	•				
	s 1 and 2 should of Health and Mer liem 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print, Eleanor I Lovick		-	-	and Number or Rur Avenue [					
w	0		20a. Method of Disposition  **Disposition 3 □ Removal f	20b. Place of cemeter			e) 5 /00		Oc. Location	•		
E E	permit. Pages Department of Important: If It any Injury or o once.		4 Donation 5 □ Other (Specify)	Garrison	1 Forest						s, Maryland eral Home Inc	
Ba	Depa Impo any la		21. signature of Funer Schied Licensee	enapis	ď.	6500	York Road	d Baltimo	re, Ma			
	Physician /Medical Examiner	Examiner	Sequentially list conditions. b	on each line.  I schemic e to (or as a consequence of the consequence)	Of):		omy opal				Interval Between Onset and Death	
•	eath certificate be executed attending physician and for use as the burial-transit	l I	resulting in death) Last  C. Du  d	e to (or as a consequence o	of):							
.O. Box	Ine law requires that the death certificate attending phys attending phys bage 2 should be detached for use as the last the last attending the las	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 ☐ Ectop 5 ☐ Other	ic pregnancy (specify)	y 			ate of delivionth	very Day Year	
rds, P.	w requires that the do been signed by the should be detached	5	Part II. Other significant conditions contributing	to death but not resulting in	the underlyin	g cause give	en in Part I.	23e. Did toba	3_/		the cause of death?	
		Completed	Atrial Fibr	Untian Disease				24a. Was an autopsy perform		Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of	
Vital V	ctan: ertific ector,	Be	25. Was case referred to medical examiner?					h (Check only one	)			
	this o	၉		1 Inpatient 2 ER/Ou			4 LI Nursing Ho	ome 5 Resider			ify)	
ב ס	ding I	ion	1 Natural 5 ☐ Pending		ime of njury M	28c. Injury	yat ⟨? Yes 2 □ No	28d. Describe how	v injury occu	rrea		
DIVISION OF	i or Attending Physician: after death, Director: After this certific: d in by the funeral director,	ertification:	3 Suicide 6 Could not be determined	Place of Injury - At home, far building, etc. (Specify)		-		28f. Location (Str. City or Town,		ber or Ru	ral Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Physician: 1 Certifying Physician: 1 Medical Examiner: On and	o the best of my knowledge the basis of examination an manner stated.	, death occur d/or investiga	red at the tir tion, in my o	me, date and place pinion, death occur	, and due to the ca rred at the time, da	use(s) and n te and place	nanner as , and due	stated. to the cause(s)	
	Northi Comp	Me	29b. Signature and title of certifier	nn		29c. Licens	e number - 7444	29	d. Date sign May	ed (Month	, Day, Year) 2008	
li	1		30. Name and address of person who completed Hexander Cher	1, MO	(Type, Print)	Box 1	9099, 7	owson,	40	212	.84	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 1 2008	32. Registrar's Signature	la fore	age of	,					
DU	IH 17 Rev 1/2	004		w.	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year **Physician** 12:25 PM JEORGE 2008 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1709 Inverness Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1X M 2 ☐ F 218-18-4699 85 Director 02-09-1923 Baltimore MD Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Inverness Avenue items 23a 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2人 No Specify Completed by Specify: White 3X Widowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the M College (1-4or 5+) n Millwright Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Charles Leda Frances Sobeski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trae 5610 Harvey Court White Marsh Maryland 21162 David Russo ( Grandson ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 5-21-2008 Dundalk Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck F.H. of Dundalk Inc. 7922 Wise Avenue Dundalk Maryland 21222 lones Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death 23a Immediate Cause (Final YEARS **Physician** HEART FAILURE CONCESTIVE resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4⊡Pregnant at time of death 5 Other (specify) signed by the a 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy perform certificate 1□ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

or Vital Records, P.O. Division To the Hospital or ..... within 24 hours after death.

To the Funeral Director: Aftrammlately filled in by the fur

H 10

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) Registrar

JENNIFER

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOS HOPKINS BAYVIEW CIRCLE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

062032

29d. Date signed (Month, Day, Year)

2008

8-03764 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
loward Arthur Lee	State of Maryland / Department of Health and M	lental Hygiene	0000 1:50							
	Registrar Oct (Indate of Death)	Reg. No.	Z11118 1 6 5 1							
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month Day	3. Time of Death Year 1006 hrs							
viedicai Examine	100000	May 17, 2008	nty of Death							
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local Carroll Hospital Center  Westminster	Carro								
			(YY) 9. Birthplace (State or							
Funeral Director	Months Days I	Hours Min.	Foreign A A							
Director	215-82-1660 1×M 2 F 45 Yrs.	1 1teb.22,19b	3 Country) Na.							
b.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits							
w any	10a. State 10b. County 10c. City, 10w1 of Eccation		1 Yes 2 No							
·land -f show	Ma. Carroll Westminster		7							
the Maryland a or 28a-f sh	10e. Street and Number	Tog. Citizen or	What Country?							
er death with the Maryland or tiems 23a or 28a-f sho cmust be notified at once. Funeral Director		5 1 6	(SH							
er death with or items 23 cmust be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani 15. Never Married 2 Married Armed Forces? 13. Was Decedent of Hispani 14. Marital Status 15. Was Decedent of Hispani 17. Marital Status 18. Yes, specify Cuban, Me		ace - American Indian, Black, /hite, etc.							
or it	1 Yes 2 No		DI							
s afte	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No sp 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (		f Business/Industry							
hour fratu Exan	Elementary/Secondary (0-12) College (1-4 or 5+)		Business/industry							
36 in 72 hhan '	College (1-4 of 5+)	Ro	ctuarant							
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	17. Father's Name (First, Middle, Last)	Nother's Name (First, Middle, Maiden Surna	Si uarani							
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple		1 1	) Ce							
2121: tould be fil d Mental Is s marked tic event,		Number or Rural Route Number, City or								
MD 3 should be s	Mcc Margo Wobb Ster 709 Charl	nayorth of wo	Stringtor MA							
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after then of Health and Mental Hygene.  Sant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.  To Be Completed by	20a. Method of Disposition 20b. Place of Disposition (Name of cemete		on - City or Town, State							
altimore, mit. Pages I ai partment of He prortant: If ite jury or other to	1 Burial 2 Cremation 3 Removal from State crematory or other place)	5/27/2008 Pois	1 1							
timen rant	4 Donation 5 Other Specify: 5t. Lyke Cemete	91.	sterslown, Ivia.							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director	21. Signature of Funeral Service Licensee 22. Name and Address of Joseph L.	Russ Funeral H	one, P.A.							
	23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc	as cardiac or respiratory arrest shock of	Ad. Z 1216  Theart Approximate Interval							
Physician /Medi∟al	failure. List only one cause on each line.	Tab cardiac or respiratory arrest, shock, or	Between Onset and Death							
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		Death							
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ī	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
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0, e be e sicial burial	Xunpended 23a,27, perME, g881 7/11/08 TT #	1, as noted per me	- T. (-1)							
ox 68760, eath certificate be attending physici for use as the buring circus as the buring circus as the buring circus as the buring of the puring the pur	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Mont	te of delivery							
cendin	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	and programs,								
Boy death	1 Yes 2 No 9 Unknown 9 Unknown									
cords, P.O. Box 68760, law requires that the death certificate be mas been signed by the attending physici 2 should be detached for use as the buring that the Devision of the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		ontribute to the cause of death?							
P.C. res that signed be dete		1 Yes 2 V No	3 Probably 4 Unknown							
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Records, The law requires ficate has been sig		autopsy performed?	death?							
tal Recting The certificate ector, page	Of New york and have first	1 ✓ Yes 2 No Death (Check only one)	1 Yes 2 No							
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Physical direction	1 V Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury 2	Training frome of transcortes								
Division of spiral or Attending P burs after death. Ineral Director: After filled in by the funeral Centification:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28b. Injury at 1 Yes	2 No								
Sicolar dear rector	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office build	ing etc. 28f Location (Street and N	umber or Rural Route Number, City							
S after of in Diric	3 Suicide 6 Could not be determined determined (Specify)	or Town, State)								
		and place, and due to the serves/s) and ma	nner ac stated							
To the Ho within 24 To the Fu completel	29a. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date a cone)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, de	and place, and due to the cause(s) and ma ath occurred at the time, date and place, a	and due to the cause(s)							
To T com	and manner stated.  29b. Signature and title of certifier  29c. License no		signed (Month, Day, Year)							
	250. Signature and title of Certifier		- ,							
	maryone me osuco	iviay 10	-							
7	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Balti	more MD 21201								
		ITIOI C, IVID Z IZU I								
Stat Registra										

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 Z004 **Physician** Scil /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours JUNE 10,193 21234-4018 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1√2 Yes 2 □ No Director MID BAITIMONE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 6 'natural", or items 23a 2/2/3 2433 5. -cdern Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: B/ACK 2 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12 Th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is marked JONES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) important: If them 27 is any injury MD . 21239 BAITIMORE AThecina 5510 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State da 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** NONUCHEMIC AFDIOMYOPATH disease or condition resulting in death) /Medical Examiner OFONALT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed as the burial-transit d by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 3 Probably 4 □ Unknown 2 🗌 No 1 Tes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be examiner? Other: Hospital: 1 ☐ Yes 2 No 4  $\square$  Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 🗆 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Pear 28b. Time of 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes death. Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) or A e Hospital of 24 hours a Euneral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only To the Hosp within 24 hou To the Funer completely fil Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ES-000

Registrar

State

SAMIT

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DESAI

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 147008 **Physician** MACNEAL HONDA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTER ANDA/15TOWN BACTOMENE KONTHWEL If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7/21/1963 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F unknown 44 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Woodlawn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5316 Dogwood Rd. 21207 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2/2 No Specify: \$ White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Self-employed marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Ronald MacNeal Nancy Gaines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Squires/Aunt 7331 Donald Ct., Woodbine, MD 21797 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 5/14/2008 South Carroll Crematory Winfield, MD 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licenses Part Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition re un in death) SEPRIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 □ No P.O. the 9 Unknown 9 ☐ Unknowr signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ģ CHILDRYC COSSTACECTIVE 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24a. Waşan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ NO certificate has page 2: GASTREIN TESTERAL Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Thipatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After the Hospital or Attending I hin 24 hours after death. the Funeral Director; After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 2 1 and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONANA

2008

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.C. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 19 2008 Day **Physician** 5:50 A Frank Andrew Myers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harrford 1515 Clayton Road Joppa If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 27 Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Days 1**X** M 2□ F 81 215 22 5111 Baltimore Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene.
ant: If item 27 is marked other than "natural"; or Items 23a or 28a-f show ury or other thaumatle event, the Medical Examiner must be notified at ury or or ther traumatle event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 📉 No Harrford Maryland Joppa Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21085 1515 Clayton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Myers Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lousia Mohr Frank Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Clayton Road Joppa, Md. 21085 Jackie M Krankowski (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any Injury or once. Baltimore, Maryland Zion Church Cemetery May 22 2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice See 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ettending physician Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ADOUR 3 Probably 2 ☐ No 4 ☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ■ Residence 6 Other (Specify) 1 🔲 Inpatient ပ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, streecify)	reet, factory, office	9	28f. Location (: City or Tox	Street and Numbe wn, State)	r or Rura	J Route Number,
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3 ☐ Widowed		If Vas Giv	ates:1942	-46	1 ☐ Yes	2XNo	Specify:	:			Specify:	WH	ITE	
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Reco	> 9 70	Completed										24a. Wa	opsv	24b. W	Vere autor	psy findings a npletion of car	vailable use of
大 Vital F	an: The tificate ha		25. Was case refer	red to medica	1					00 Pi	( D !!		formed? 2.X N	o 1	eath? □Yes	2□ No	
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i at	ding Phys J. After this funeral di		27. Manner of Death	5 Pendin	9	of Injury h, Day Year)	28b. Time Injury		8c. Injur		LAI.	8d. Describe	how inju	ury occurre	ed		
fuctor or vision or	Attending or death. ector; After by the fune	Certification:	2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide	investiç 6 X Could i determ	not be 28e. Place	of injury - At ho	unk ome, farm, s	M street, factory		Yes 2 🔀	• '	ink 8f. Location	(Street a	ınd Numbe	er or Rura	l Route Numb	er,
古	Hospital or 44 hours afte Funeral Dir tely filled in			<b>U</b> -	unk	-					- 1	ink					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one)	2 Medical	ng Physician: To the Examiner: On the ba and mann	best of my kno asis of examina aer stated.	wledge, dea ation and/or	ath occurred investigation	at the tir , in my o	me, date ar ppinion, dea	nd place, a ath occurre	and due to the ed at the time	e cause(s e, date ar	s) and mar nd place, a	nner as st and due to	ated. the cause(s)	
	To th To th comp	M	29b. Signature and	title of certifie	16			290	. Licens	e number			29d. Da	ate signed	(Month,	Day, Year)	
	1		30 Name and adds	ess of person	who completed caus		1 23 (Type	2 Print)	18	1 1	1		//	lay	19,	2008	
1	· L		Brian	· Hol	ly 30	1 54.	fan	i Oi	E	Saltin	more	MI	)	212	02		
	Sta Registr		31. Date filed (Mon	th, Day, Year) AY 2 1		egistrar's Signa	ature	we									

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1625 P Elizabeth McManus May 8,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 90 Months Days Hours Min. 1 □ M 2★□ F September 21. Louisiana Director 578-32-0276 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expendent must be notified at 1 ☐Yes 2 ☐ No Directo Maryland Prince George's Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13601 Belle Chasse Blvd 20707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) **Private** Homemaker Twe1th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Boudreaux David Della 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. 13601 Belle Chasse Blvd., Laurel MD 20707 Elizabeth Gray/Daughter 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 10ate 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 3 Removal from State Arlington National 2008 Arlington, VA 5 ☐ Other (Specify) Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Sign tur of 1661 Good Hope Rd SE, Washington DC 20020 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Tyes 2X No. is been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation or. safter dea. ral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066402 May 8,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Jung Chun M.D. 1500 Forest Glen Road, Silver Spring MD 20910 31. Date filed (Month, Day, Year) 32. Pristrar's Signature State MAY 2 1 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:24 PM May 16, 2008 Herbert Ott /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MD General Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 24, 1937 5. Social Security Number 7 Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6 Sex PA **Funeral** Months 1 X M 2 □ F 132-28-2396 70 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturai", or items 23a or 28a-f show di∵al Ex∗miner must be notifled at n/a Baltimore 1 ☐ Yes 2 No MD Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 United States 1627 Eastern Ave. Apt. 408 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ho If Yes, aver year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than 'arry or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Weisenfluh Herbert Ott ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 3 3 19a. Informant's Name/Relationship (Type. Print) 3914 Falls Run Road Randallstown, Clergy Rev. Edward Terry Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State permit. Page Department of Important: If any injury or South Carroll Crematory May20, 2008 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Lice 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. I nmedia e Cause (Final de e or condition **Physician** CARDIAC ARRYTHEMING minua resulting in death) /Medical Due to (or as a consequence of): Examiner minulas Atherosclerone heant disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Quelto for as be executed Hypertonsian 1045 burial-tran Due to (or as a consequence of): Box 68760. physician Demenha Physician/Medical 544 attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a P.0. 9 I Inknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown mainutition pheumonia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an aw page 2 s 385 autopsy certificate I 2 No 1∐ Yes or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After Hospital or Attending 1 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 PPFUED 5/19/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 716 maiden choice lane Catonsville KNESAIMO maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 21

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 201218 MAY 9:30P M 17. Joyce Marie Ortt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🗙 F 09/19/1932 Director 75 Massachusetts 030-24-0486 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 X No Director MD Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Box Hill S. Parkway - Apt. Funeral 21009 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ss 1 and 2 should be filed wi of Health and Mental Hygier Item 27 Is marked other th other traumatic event, the Medical\_Industry Medical Biller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stewart N. McLeod ၉ Marguerite Lund 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Cannongate Road - Forest Hill, Maryland 21050 <u> Linda Gallagher (daughter)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ites
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.John the Evangelist 05/21/2008 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BILATERAL PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last that the death certificate be exec Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 X No Month 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown CUTANEOUS LYMPHOMA 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 N No 24a. Was an has autonsy performed? Yes 2 No page 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) **¾**□ No 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 1X Inpatient this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After or Attending (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

DHMH 17 Rev 1/2001

State

Registrar

29h. Signature and title of kertifier

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JOGINDER P.

MAY 21

31. Date filed (Month, Day, Year)

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2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760,

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or Vital Records,

Division

M.D., 7601 OSLER DRIVE.

2002

M-ehle, m.D

2. Registrar's Signature

29c. License number

D 41412

29d. Date signed (Month, Day, Year)

MARYLAND 21204

WWA

TOWSON.

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Raymond Peguese 2008 4:45a. 05 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2 □ F Director 250-48-6409 76 06 18 31 SC Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiens (2 invoits aller death with the Maryla Inportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Evantine must be notified at once. 1 □Yes 2 No Funeral Director Parkville MD Baltimore Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 <del>7238</del> Sindall Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces' 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>Ş</u> Specify: X□ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pratt Whitney Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver Aircraft 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Hettie L. Coakley James King Pequese ပ္ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7235 Sindall Road, Parkville, Md 21234 <u> Virginia Peguese-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Beginnings Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christian Church 5/17/08 21. Signature of Funeral Service Licensee March F/H West 23a. Part 1. End, the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one callse on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) aLIVER DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) rsician and burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 😿 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 Other (Specify) HOSPICE 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 X Natural death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 108

State Registrar

4:45 a.m.

2008

RAYMOND PEGUESE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5/19/2008 Robert E. Parks 8:07 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 → M 2 □ F Director 214-20-2632 9/12/1927 80 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Heath and Mental Hygiene. nt: If Nem 27 is marked other than "natural" or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XNo Director Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 6601 Jacks Ct. 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1944–48 1 ☐ Yes 2 X No þ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 4 **CPA** C.R. Daniels 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be John Parks Lillian Mae Parker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra Hollis Parks/Wife 6601 Jacks Ct., Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 5/20/08 4 Donation 5 ☐ Other (Specify) Winfield, MD South Carroll Crematory of Funeral Service Licen 2Burrierd Guelen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 art . Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest c on each line. Approximate Interval Between Onset and Death Immediate Cause (Final di seasa or condition reasand in death) **Physician** Von-Smal ung Cance /Medical Due to (or as a consequence of) Examiner apacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to for as a sunsequence of Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) iuse Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury

Hospital or Attending Physician: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician been signed by should be detacl has certificate After this after death Director:

Baltimore, Maryland 21215-0036

within 24 hours a

To the Funeral I

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

2541

29b. Signature and title of certifier

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 TYes

2 ∏No

29d. Date signed (Month, Dav. Year)

6 Could not be determined

Year)

1

Location (Street and Number or Rural Route Number, City or Town, State)

leted cause of death (Item 23a) (Type, Print) 30. Name and address of person v 31. Date filed (Month, Day, Y

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19, 2008 Month **Physician** 2:31 PM Lela Alice Probst May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 301 N. Fountain Green Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 220-20-7587 83 Sept. 29, 1924 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 N. Fountain Green Road 21015 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Gas and Electric Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover Howard Marsh Lela (UNK) Evans ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Eugene R. Probst / Spouse 301 N. Fountain Green Road, Bel Air, Maryland 21015 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion UM Cemetery 5/24/2008 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland, 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ANEURYSM Immediate Cause (Final ADRITC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): A pue physician and X the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1□ Yes 2 No 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cerofier D31775 131775 MAY 20, 2008 THUSTON MARYLAND 21047 ١D eleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co MO

DHMH 17 Rev 1/2001

State Registrar

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î	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
120	/Media	cal	Robert Victor Phelps		-	41 O'T T				01:05FM
·	Examir	ier	4a. Facility Name (If not institution, give street and num Saint Joseph Medic	al Cen	ter	4b. City, Town, or	Location of Death TOWS	on	4c. County of	altimore
	Funeral Director		5. Social Security Number 6. Sex 1 X M 2 □ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 28,	, Year)	9. Birthplace (State or Foreign Country) Maryland
	put »		Usual Residence of Decedent  10a. State 10b. County	10c Cits	, Town or Lo	cation				10d. Inside City Limits
	Maryla f shoved at	٥	Maryland Baltimore			Callon				1 □ Yes 2 No
	r 28a-	Director	10e. Street and Number	TIM	onium	10f. Zip Code		1	10g. Citizen of Wh	at Country?
	th with 23a o	al D	305 Five Farms Lane			21093			U.S.A.	
•	d within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Dece Armed Fo			Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or D	/e		I ☐ Yes 2X No	Specify:		Specify:	White
9-0	2 hou latura ical E	ted	15. Decedent's Education		16a. Dece	lent's Usual Occupa	ation		16b. Kind of Busi	
218	within 7 iene. than "r he Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+)		kind of work done o		ng		
121	e filed w al Hygier other th		12 17. Father's Name ( <i>First, Middle, Last</i> )		Busi	ness Owne	r 18. Mother's Name	/Eirst Middle		ic Control
Maryland 21215-0036	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, once.	To Be	Leonard Hugh Lee Phelps				Edna May		,	'
aryl	shoul and Ma mari	F	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	g Address (Street a				tate, Zip Code)
	and 2 ealth a n 27 ls		Glenda Lee Phelps (Wife)			ive Farms			MD 21093	
ore	ges 1 t of He If Iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	State 20b. P	lace of Dispo emetery, crer	sition (Name of natory or other plac	e) [	Date	20c. Location - C	ity or Town, State
Baltimore,	t. Pag rtmen rtant: njury	9	4 Donation 5 □ Other (Specify)		ience		4/18/	08	Aurora,	CO
Ba	permii Depar Impor any Ir	11, 11	21. Signature of Funeral Service Licensee			Name and Addres Science C 19301 E.	23rd Ave.			011
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death ach line. <b>R</b> é	n. Do not ent enal A	er the mode of dying rtery Ath	g, such as cardiac deroscler	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MY 1 f 1	ILUKE					2 YEARS
	Examiner			or as a consequ	LURE	Coronary	Artery D	isease		5 YEARS
		ner	cause Enter Underlying	or as a consequ	uence of):				16 6 2 6 2	
	ecuter and trans	Examine	that initiated events	or as a consequ						
68760,	icate be executed physician and the burial-transit		Sue to	or as a consequ	derice orj.					
	ificate g phys as the	edical	d							
Box	w requires that the death certifit been signed by the attending I should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	come pf pregna irth 2  Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	,
P.O.	that the		9 ☐ Unknown  Part II. Other significant conditions contributing to de		ulting in the ur	nderlying cause give	en in Part I	23e. Did to	bacco use contrib	ute to the cause of death?
Records,	requires that the een signed by th	ted by						1 □ Y	1/	☐ Probably 4 ☐ Unknown
II Rec	The la ate has page 2	Completed						24a. Was a autop perfor 1∐ Yes	sy pri med? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
or Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Otho	26. Place of Death	Check onl or	ne	
ō	Phys rr this eral dir	٦. ا	1 Yes 2 No No 28a. Date	npatient 2 1	ER/Outpatien 28b. Time of		4 Li Nursing Ho		ence 6 Dother	
ion	Attending Phr r death. ector: After thi by the funeral	ation	1 Natural 5 ☐ Pending (Monitor) 2 Accident investigation	h, Day Year)	Injury	28c. Injury Work M 1 🗆 \	r? Yes 2 □ No			
Division	al or Atte after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildi	of injury - At ho ng, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the beautiful Medical Examiner: On the beautiful Medical Examin	best of my know asis of examinat ner stated.	wledge, death tion and/or in	occurred at the time time time of	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and mani date and place, an	ner as stated. Indicate to the cause(s)
	To the Mithing Comp.	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (	(Month, Day, Year)
	(2)		1/9			DES	Ø96		4001	1+ 2008
			30. Name and address of person who completed caus	- 1		· ·	CD Noti	TOU	TON MAD	YLAND 21204
A.	Sta		DAVID A. UTZSCHNEID  31. Date filed (Month, Day, Year)  MAY 2 1 2008	ER M		601 DSL	EK DKIA	I UW	SON, MAR	TEMPINE ELECTIVIT
	Registr	aı	MINI OT TOO	15 Wall 200	1					

Registrar DHMH 17 Rev 1/2001

## State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) **Physician** Maria Padilla. Rodriquez /Medical 4a. Facility Name (If not institution, give street and number) Examiner Doctor's Community Hospital 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🖸 F Director 218-92-4095 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show notified at Director Prince Georges Maryland

Mitchellville 10e. Street and Number 12100 Kings Arrow Street 12. Was Decedent Ever in u.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married

College (1-4or 5+)

15. Decedent's Education (Specify only highest grade completed)

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No Specify: 16a. Decedent's Usual Occupation

20721

10f. Zip Code

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Lanham

Certificate of Death

4b. City. Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

14. Race - American Indian, Black, White, etc. Specify: Mexican

9:00PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Mexico

(Give kind of work done during most of working life. DO NOT use retired) Homemaker 18. Mother's Name (First, Middle, Maiden Surname)

Own Home

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) Manuel Padilla

3 X Widowed 4 Divorced

Elementary/Secondary (0-12)

Department of Health and Mental Hygiene. Incurs ariet usern will be beautiful for them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be once.

Physician

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

To the Hospital

/Medical Examiner

physician and s the burial-trans

use as attending p

ed by the a detached f

signed by

page 2 should been

funeral director.

After this

To the nosperate death.

Within 24 hours after death.

To the Funeral Director: Aft

has

Pages 1 and 2 should be

Funeral

Completed by

Be

ဥ

Examine

Physician/Medical

Completed by

Be

٩

Certification:

Medical

Margarita Gonsalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12100 Kings Arrow Street, Mitchellville, MD 20721

Mexican

Date

Estela Padilla- daughter 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State

19a. Informant's Name/Relationship (Type. Print)

20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Mem. Pk. May 16,2008

20c. Location - City or Town, State Laurel, Maryland

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Licensee low MO123

22. Name and Address of Facility Fleck Funeral Home, INC.

7601 Sandy Spring Road, Laurel, Maryland 20707

2. Date of Death

Month

Day

0

Mexico

February 28, 1917

2008

Prince georges

4c. County of Death

10g. Citizen of What Country?

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unleach line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to him equate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

neumonia eart fullur

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Approximate Interval Between Onset and Death

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death?

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 TYes 2 No

25. Was case referred to medical 2**X** No 1 Yes

5 ☐ Pending

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

27. Manner of Death

1 Natural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

investigation

6 Could not be determined

29c. License number D52500 29d. Date signed (Month, Day, Year) 05/13/08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

death (Item 23a) (Type, Print) 30. Name and 8118 Good LuckRd., Lanham, MD. 20706

31. Date filed (Month, Day, Year)

MAY 2

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 19, 2008 Year WALTER ROBINSON 3:37P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2808 D Kings Ridge Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 26 9'. Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F Days Months Hours 94 Director 216-01-0277 1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Experient must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 □Yes 2 □No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2808 D Kings Ridge Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★ Wes 2 □ No WW If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Wesley Robinson Suzie Elizabeth Kerchner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W Robinson Son 3828 Ayres Court Baltimore, Maryland 21236 20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Parkwood Cemetery May 22,2008 Parkville, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMitchell-Wiedefeld Funeral Home Irc ignature of Funera nnes 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease **Physician** obstructive hrome ears resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for an a consequence of Examiner To the Hospital or Attending Physlcian: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, disorder 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Ves 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a, Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number
1) 252d5 29d. Date signed (Month, Day, Year)
MA720, 2008 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) les St. Golfon 1 20204

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2008 6:35 Eloisa 0. Rivera Mav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore Rosedale 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 85 1 M 2 1 F Director Mar22,1923 212-26-0871 Puerto Rico Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Md. Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 9106 Abigail Drive Apt 2C U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1≝Yes 2□No Specify: Puerto Rican 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Hispanic 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Toribio Castillo Nicolasa Silva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Maney (daughter) 17 Waldmann Mill Court Nottingham,Md.21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 5-22-2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TYOCARDIAL Due to (or as a consequence of): ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown

**Physician** /Medical Examiner

death certificate be executed

P.O. Box 68760,

Division or Vital Records,

Department of Health a important: If item 27 is any Injury or other train

2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

burial-trar and physician the burial attending for use as ed by the a signed by the þ Completed certificate has funeral director, Be ဥ e Hospital or Attending P 24 hours after death. Funeral Director: After t After Certification: filled in by the

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D044315

29d. Date signed (Month, Day, Year)

May 19, 2008

within 24 hours a

State Registrar

29a. Certifier

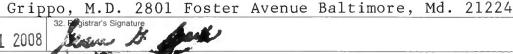
(Check only

29b. Signature and title of certifier

Vincenzo

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



08-03781
Linda Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 17, 2008 2233 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore Johns Hopkins Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Min Months Country M. Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location BrookLyn 10b. County 106 2 X No or items 23a or 28a-f show must be notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 2725 21225 SEA MON 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status Armed Forces? 1 Never Married 2 Married Yes 2 No specify: If Yes. Give Yea Yes 3 Widowed Pages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", other traumatic event, ib. Medical Examin<u>er</u> 1 ş 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) 21215-0036 12 tt NO 17 Father's Name (First, Middle, Last Be Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event, 19b. Mailing Address (Street and Number or ural Route Number, City or 19a. Informant's Name/Relation hip (Type, Print e Amen Baltimore, MD Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Foneral Service Licenses Approximate Interval toline 5 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Methadone intoxication Immediate Cause (Final disease ≒xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X AMENDED #23a, PII.27.28a-t. OCX.d., perFH, C879 5/21/08 X UNPENDED ned by the attending physician detached for use as the burial the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown ⋧ Hypertensive cardiovascular disease; asthma Completed 24b. Were autopsy findings available 24a, Was an page 2 should autopsy prior to completion of cause of death? performed certificate has Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital funeral director, Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 After this ဥ 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Natural 1 Yes 2 Y No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending Fnd 5/17/2008 FNd 10:10 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be State) Suicide or Town, State) 811 N. PAtterson Park Ave. townhouse/ rowhouse 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 18, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

Registra

31. Date filed (Month, Bay Year) 008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** STILWELL 2008 510 DOROTH A MAY ZELMA ь /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL OF CHESAPANE HARWOOD HOSPICS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗹 F 8552 NEW YORK MAY 26, 191 9 21452 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Exporter must be notified at 1 □Yes 2 ☑No Director ANNE ARUNDEL ANNAPOLIS 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number death with 2140 USA AUGNUE RIBUELY Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene, 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: WHITE à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) tt of Health and Mental Hygiene, if item 27 is marked other than or other traumatic event, I've Mi Elementary/Secondary (0-12) 10ME MAKES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHORLES CHAPMAN ETHELINES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21401 ANNEPOLIS MAHLON STILWELL RIDULLY AUGUE 646 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. HYDOURS MORYUSAL 4 Donation 5 ☐ Other (Specify) ANATOMY WIFTS PELLISTRY MAY 21,2000 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ANATOMY LIFTS PLLISTRY 91076 Den 2272 MINELLEY PRIME HANGUNZ. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 WOWTH **Physician** Eleman Con /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnency
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 200 1 ☐Yes 2 🗷 1 □Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending investigation n 24 hours after death, ne Funeral Director; Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

In Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated.

In Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and manner as stated.

In Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title eted cause of death (Item 23a) (Type, Print) Name end 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD CO THOMAS VAUGHN NURSING CARE **ABERDEEN**  Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 XM 2 □ F 579-54-175 Yrs 56 1 1942 APR. WASHINGTON, D.C. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2\OXNo Director ABERDEEN HARFORD CO MARYLAND 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 'natural", or items 23a or dical Examiner must be 21001 106 SPESUTIA RD. U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCILLE HARRIS 2 LEONARD SKINKER SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5032 6th St. N.E., Washington, D.C., Leonard Skinker Jr./Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1
nent of F
int; If ite ¥XBurial , 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, 05-28-08 CHELTANHAM, MARYLAND 4 □ Donation 5 □ Other (Specify) CHELTANHAM VETERANS 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 Wellara Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner om Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown <u>م</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 455 HM 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို Division or 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Magner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

9 5 5°

State Registrar 31. Date filed (Month, Day, Year) MAY 2 1 2008

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

VAMHCS, PERRY POINT, HD21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 17, 5:36 P M May 2008 Charles Howard Sibley Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 19, 1 5. Social Security Number **Funeral** Days Hours 1**X** M 2□ F Yrs. 1916 Maryland 91 213-03-4419 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or items 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Churchville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 202 Rhineforte Drive 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Importent: if item 27 is marked other then eny injury or other trainmests. Elementary/Secondary (0-12) College (1-4or 5+) Sprinkler Systems 10 Welder 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Louisville Bowen Charles Howard Sibley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Rhineforte Dr., Churchville, MD 21028 Joan Favazza / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Dulaney Valley Mem Gd 5-22-08 Timonium, Maryland 21. Sunature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or research allure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Lays Physician lan /Medical Examiner agun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ፩ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed? 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer of To the Funerel Direct completely filled in by 4 - Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier D32609 118108 Whian NO

Registrar DHMH 17 Rev 1/2001

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32 Registrar's Signature

3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mulhary MD

2008

Kamrudy 31. Date filed (Month, Day, Year)

MAY 21

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16,200 S 4c. County of Depath

4b. City, Town, or Location of Death

Himore

Year If Under 24 Hrs.

8. Date of Birth

3. Time of De

**Examiner Funeral** 

**Physician** 

/Medical

4a. Facility Name (If not institution,

ecurity Number

give street and number

enuce

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. show or 28a-f show notified at "natural", or items 23a or dical Examiner must be r Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

the death certificate be executed burial-tran attending physician for use as the buria detached funeral director, page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760,

Age (In yrs. last birthday, 52 Yrs. Birthplace (State or Foreign Country) Min (Month, Day, Year) 08/25/1955 217-50-0130 1 X M 2 □ F Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2730 Louise Avenue 21214 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☐ Widowed 4 🏿 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Buildina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Stockett Betty Lucille Scheib 19a. Informant's Name/Relationship (Type. Print) Randall Stockett/Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2515 Wilson Road, White Hall, MD 21161 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Meadowr Tage Memoleca al Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/19/2008 Elkridge, MD 22. Name and Address of Facility Ruck Towson Funeral Home, 21. Signature of Buneral Service Licensee 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nuence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performad? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a prilip of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause 23a) (Type, Print

State Registrar 32. Aegistrar's Signatur

nth, Day,

Year)

State Registrar

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Registra s Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2008 May 18, **Physician** Helen E. Sitterle 2:00 a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12933 Kentbury Drive Clarksville Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 27, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 122-10-8905 1 M 2 F Months 92 Director NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f sho dical Examiner must be notified at MD Howard Director Clarksville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12933 Kentbury Drive 21029 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Advance Contact Lenses than, Elementary/Secondary (0-12) 12 College (1-4or 5+) Operator / Owner Manufacturing is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Lawrence Chadwick Elizabeth McEniry item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine A. Sitterle / Daughter 12933 Kentbury Drive, Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite injury or ( 35Removal from State 1 ☑ Burial 2 ☐ Cremation May  $\frac{22}{21}$ Elmlawn Cemetery 2008 Tonawanda, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Charles L. Stevens Funeral Home Inc. W- Marshall 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failer disease or condition resulting in death) nonths Congestine /Medical Due to (or as a o sequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran-Due to (or as a consequence of) Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 autopsy performed?

1 Yes 2 No r this certificate has ral director, page 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No funeral dir 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury Director: 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 ☐ Homicide 1 Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 053636 May 19, 200, NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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2008

Division or Vital Records, P.O. Box 68760,

10700

32. Registrar's Signature

Charter Disce Columbia

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			Decedent's Name (First, Middle,	Last)							2. Date of De	ath	Year	3. Tim	e of Death
	Physici /Medic	_	Steven Scott								April	21, Day	2008	2:4	5 PM M
	Examin		4a. Facility Name (If not institution, 11 W. 20th Str		r)			rown, or time	Location of	f Death		4c. 0	County of Dea	th	
I	Funeral Director		5. Social Security Numberunk	6. Sex 7. A 1 X M 2 ☐ F	ige (In yrs. 64	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da Oct 2,	y, Year)	C	thplace (Sta ountry)	te or Foreign unk
	pu *		Usual Residence of Decedent  10a, State 10b, County		10c Cin	y, Town or Lo	cation							10d Incide	City Limits
	eho eho	5	MD			ltimor									es 2 □ No
	the A	Director	10e. Street and Number		Ju		10f. Zip (	Code				10a. Citiz	en of What C	ountry?	
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	death	Funeral	11. Marital Status unk	12. Was Deceden		S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Spec	ify Yes or No	)- 1	4. Race - Am		),
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land	o d is D	To Be	17. Father's Name (First, Middle, L	ast)			unk	κ.	18. Mother	r's Name	(First, Middle	, Maiden S	Sumame)		unk
Maryland	17 P B B B B B B B B B B B B B B B B B B		19a. Informant's Name/Relationships Baltimore City		\+	19b. Mailin	ng Address	(Street a	and Number	r or Rurai	Route Numb	er, City or	Town, State,	Zip Code)	unk
ā,	s 1 and 2 of Health item 27 i		20a. Method of Disposition	TOTICE Dep	20b. P	lace of Dispo			-1	Da	ate	20c. Loc	ation - City or	Town, State	•
Ë			t ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ※ Other (Sp.		8	emetery, crei	natory or of	ner placi	9)						
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signatur of Funeral Service L Ronald S		ector					Sard 21201	655 W.	Balt	timore	Stree	t
			23a. Parti. Enter the disease, or o shock or heart failure. List o	complications that cause	ed the death		altimo ter the mode				respiratory a	rrest,		Approxi	mate Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. A	ute	m	10con	clia	1 =	Int	archie	n		Onset a	nd Death
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	uted d insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequ	uence of):									
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687	ficate phys s the	edical	7.5	d											
. Box	death certificate be executed e ettending physicien and ad for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Feta	death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>					2	3d. Date of de Month	livery Day	Year
P.0	at the de by the estached	Phys	9 Unknown	9□ Unknown											
of Vital Records,	requires that the reen signed by th hould be detache	Ď	Part II. Other significant condition  (1) Diabeti	es Melli	tus.	ulting in the u	inderlying ca	luse give	en in Part I.		~	,	se contribute t		of death?
900	S S S	ompleted	(2) Hyper	tension	/						24a. Was		24b. Were a	utopsy findir completion	ngs available
E .	The ete h page	Con	(3) Hyper	rimobidii							perfo	2 No	death? 1 ☐ Ye	1	
/ita	sician: certifice rector. p	Be	25. Was case referred to medical examiner?	0		7.00		Tax		of Death	Check only	orle)		,	
<del>_</del>	Physician: this certific ral director.	၉	1 ☐ Yes 2 No			ER/Outpatier			4 11401				Other (Spe	ecify)	
	D 2 0	tlon	27. Manner of Seath  Natural 5 Pending  Accident investiga	/// / / /	ay Year)	28b. Time o Injury	M ZE	Bc. Injury Work	γατ ∢? Yes 2.∐.N		8d. Describe	now injury	occurred		
Division	ten tor: the	Certification:	2 Accident investigation inves	ot be 28e Place of I	njury - At ho	ome, farm, str			.00 201		8f. Location ( City or To	Street and wn, State)	1 Number or A	ural Route I	Number,
	To the Mospitei or Al within 24 hours efter of To the Funerel Direc completely filled in by		29a. Certifier	Physician: To the bes	st of my kno	wledge, deat	h occurred a	at the tim	ne, date and	d place, a	nd due to the	cause(s)	and manner a	s stated.	
	To the He within 24 To the Fu completel	ledical	one)	xaminer: On the basis and manner:	of examina stated.	tion and/or in				th occurre	d at the time,				
)	Viti To CO	Σ	29b. Signature and title of certifier	M 200,	101	U	29c.	License	o number	210	74	1.1.	signed (Mon 1908	τπ, Day, Yea	r)
in the second			30. Name and address of person w	to completed cause of	death (Item	23a) (Type,	Print)	#	706	, P	altin	note	M	Dal	2002
	Sta Registr		31. Date filed (Month, Day, Year)	2008 33 Regis	strar's Signa	y A	alle								

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

/Medical

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After

Physician/Medical Exam as Re Completed by page 2 F Certification: hours after death.
uneral Director: A Vithin 24 hours are:

To the Funeral Dir Medical

3 ☐ Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

6 ☐ Could not be

Miller

2008

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determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	10-	( )	7922 V	Wise Ave. Du	ndalk, Mary	land 21	222
	23a. Part1. Enter the disease, or company shook, or heart failure. List only	plications that caused the deat one cause on each line.	n. Do not enter the me	ode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. CONG	BSTIVE P	HEART FAIL	URE		- Onloot and Boatin
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5	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):		4		
	that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):				
2		_d					
y signal wines	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 ☐ Ectopic			23d. Date of de Month	livery Day Year
	Part II. Other significant conditions of		ulting in the underlying			o use contribute t 2 No 3 P	o the cause of death?
and Inco					24a. Was an autopsy performed′ 1∐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
2	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)		
	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□ □	OOA Other: 4 Nursing	Home 5□Residence	6 □Other (Spe	ecify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

4940 EASTERN ALENUE

and manner stated

32. Registrar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

			For State Registrar	State of Marylar	Certificate of Death	Reg.	0000 10000
E	Physici	an	Decedent's Name (First, Middle,	Last)	Sc	2. Date of Death Month	Day Year 3. Time of Death
1	/Medi	cal	4a. Facility Name (If not institution,	Speed give street and number)	4b. City, Town, or Location of		4c. County of Death
	LXAIIII	ICI	1711 E.Oli	ver St.	Baltimo	ore	NA
**************************************	Funeral Director		5. Social Security Number  226-12-4825  Usual Residence of Decedent	6. Sex 7. Age (In yrs	. last birthday) If Under 1 Year If Under 1 Year Months Days Hours	24 Hrs. 8. Date of Birth Min. Sept. 5, 1	ary 9/Birthplace (State or Foreign Gountry)
	yland how at		10a. State 10b. County	10c. C	ity, Town or Location	24	10d. Inside City Limits
	he Mar 8a-f sl otified	ector	Md. N	A :	Baltimore	140	1 DYes 2 No
	23a or 2 ust be n	Funeral Director	10e. Street and Number	Jer St.	10f. Zip Code 2/2/3	10g.	Citizen of What Country? USA
98	s 1 and 2 should be filed within 72 hours after death with the Mary/and f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	If Yes, Give	J.S. 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc.
5-0036	tours:	ed p	3 Widowed 4 ☐ Divorced  15. Decedent'	Year or Dates:	16a. Decedent's Usual Occupation	166	. Kind of Business/Industry
2	ithin 72 ne. nan "na Medik	Completed by	(Specify only highest Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	et of working	1 (1:1 (1
7	filed with Hygiene other than		17. Father's Name (First, Middle, L	ast)	1 Crane Opera	A. Dr	astern Stainless Stee den surname)
/lan	should be nd Mental marked o	To Be			unk A	da White	2
Maryland	d 2 sho		19a. Informant's Name/Relationsh	ip (Type. Print) (Significan	19b. Mailing Address (Street and Number	= 1 D	ty or Town, State, Zip Code)
	es 1 and 2 of Health fitem 27		20a. Method of Disposition	20b.	Place of Disposition (Name of cemetery, crematory or other place)	Date 200	L Location - City or Town, State
Baltimore,	Pag nent ant: I		1  Burial 2  □Cremation 4  □Donation 5  □ Other (Sp	3 ∐Removal from State   →	arrison Forest:	5/23/2008 0	Wings Mills, Md
Ball	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service L	icensee:	22. Name and Address of Facility  Joseph L. Ry	iss Funera	Home P.A.
	175.08		23a. P nt1 Enter the # sease, or of s to k, or heart fillure. List of	complications that caused the dea	1) 12222 W. North ath. Do not enter the mode of dying, such as		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	•	ASCULAR DISE	EASE	Onset and Death  UNKNOWN
	/Medical Examiner			Due to (or as a conse	quence of):		
7	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a conse	quence of):		
٧	execute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	quence of):		
68760,	tificate be executed g physician and as the burial-transit	ledical E		d			
			IF FEMALE:	23c. If yes, outcome pf pregr	nancy		23d. Date of delivery
Box	he law requires that the death cert ie has i een signed by the attending ge 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 ☐ Ectopic pregnancy		Month Day Year
P.0	that the de		9 ☐ Unknown  Part II. Other significant condition		sulting in the underlying cause given in Part I	23e. Did tohac	co use contribute to the cause of death?
Division or Vital Records,	w requires t feen signe should be	d by			outing in the underlying educe given in that i	1 ☐ Yes	2No 3 Probably 4 Unknown
eco	e law red has f ee je 2 shou	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B	(0 17					performed 1  Yes 2	death?
. Vit	ystclan: is certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	Othor:	e of Death <i>(Check only one)</i> ursing Home 5 <b>X</b> Residence	e 6 □Other (Specify)
n or	ding Phy 1. After this funeral o		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury	28b. Time of lnjury 28c. lnjury at Work?	28d. Describe how i	
isio	att att	icatio	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Place of injury. At h	M 1 ☐ Yes 2 ☐ nome, farm, street, factory, office		t and Number or Rural Route Number,
Οį	tal or Attendl s after death. al Director: A ed in by the fu	Certification:	4 ☐ Homicide determin	building, etc. (Spec	ify)	City or Town, S	tate)
	Hospi 24 hour Funer tely fill	Medical (	29a. Certifier 1 X Certifying (Check only one) 2 Medical E	Physician: To the best of my kn     xaminer: On the basis of examin     and manner stated.	nowledge, death occurred at the time, date an action and/or investigation, in my opinion, dea	nd place, and due to the caus ath occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	100	29c. License number		Date signed (Month, Day, Year)
	3	1	30. Name and address of person v	who completed cause of death (Ite	em 23a) (Type, Print)		5/19/2008
	1		AMIT KHOSL	A, MD , 3901	I THE ALAMEDA,	, BALTIMOR	E, MD 21218
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	H And		
DH	MH 17 Rev 1/2		MAY 2 1	2008 Misur			

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 19 **Physician** 2008 CLARICE E. TARIER 10:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign Country) FUTURE CARE- LOCHERN Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9–23–1912 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2√□ F 95 MD Director 722-10-9/1/3
Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Medical Examiner must te notified a traumatic event, 1 XYes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 N. Calhoun Street 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No African-American Specify. ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) Self Employed Damestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Rufus Mossel Maudie Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Clarice H. Johnson/Daughter 1201 N. Calhoun Street, Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Arbutus Memorial 5-27-08 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. re of Funeral Service Licenses 9200 LibertyRoad, Randallstown, MD 21133 Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): disease Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached signed by I significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar utaw St. #308 Baltimore MD 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

08-03832 Lisa D Tynes

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

isa D Tynes	1- For State of Maryland / Department of Health and Mental Hygierie  Certificate of Death	531				
Physician/	Registrar 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 3. Time of Death	70				
Medical Examiner ❤️෭	Month May 19, 2008  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death					
	740 Poplar Grove Apartment 7P Baltimore					
Funeral Director	5. Social Security Number  3. Social Security Number  4. Age (In yrs. last birthday)  4. Months Days Hours Min.  4. Dec. 10, 1972  4. Country) Mary	and				
d d	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside eity 1 Ves 2					
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Maryland NH Battimore 1 Nes 2 [ 10e. Street and Number 10f. Zip Code 21216 10g. Citizen of What Country?  Wes 2					
r death with or items 23	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black White, etc.  White, etc.	,				
ours after atural", aminer	3 Wildowed 4 Divorced in test slive feel 1 Feet 2 No specify. Specify.	$\dashv$				
5-0036 lied within 72 hour lied within 72 hour Hygiene. I other than "matu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+)					
21215-00 ould be filed win I Mental Hygier marked other is event, the M	Reginald lynes Shiney McManon					
ore, MD 21215-00: so I and 2 should be filed with of Health and Mental Hygiene If iten 27 is marked other t her traumartic event, the Mer To Be Com	Anthory Holley - france 140 poplar crove st. nft 18 Baltimore	湖。				
E graph and	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Wethor Crematory  5/26/08  Catorsville, Mary	land				
Baltil permit. Departm Importa injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home (A) 3512 Frederick Are. Bastimer Maryland	1229				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lifeart failure. List only one cause on each line.    Immediate Cause (Final disease   a. Narcotic (methadone and morphine) into xication	et and				
xaminer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.					
red usit						
cuted and transit	events resulting in death) Last  Due to (or as a consequence of):  d.					
'60, ate be execut physician and he burial - tra	X UNPENDED  AMENDED, 28a-f, perME, g880 6/5/08 TT  L23c. If yes, outcome of pregnancy  23d. Date of delivery					
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transified ical Certification: To Be Completed by Physician/Medical Exhedical Certification:	IF FEMALE: 23c. If yes, outcome of pregnancy 1	ar				
P.O. Bo. that the de med by the detached for by Phy						
ds, Frequires	24a. Was an autopsy prior to completion of cau	vailable				
Records, The law requires froate has been significate to the speed 2 should be Completed	autopsy prior to completion of cau performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2					
tal Fician: Certific ector, I	25. Was case referred to medical examiner?					
of Vir Physic er this eral dir	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Violent Scene					
on c ending arth. or: Af or: Af	1 Natural 5 Pending Fnd 5/19/2008 Fnd 7:02 pm 1 Yes 2 X No unk					
Division or spiral or Attending tours after death.  meral Director: After filled in by the func Certification:	2 Accident Investigation 3 Suicide 6 X Could not be determined (Specify) found at home 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found at home 28f. Location (Street and Number or Rural Route Number of Town, State) Falt Imore, 1740 Poplar Grove Apt. 7P	er, City				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the						
To To Mec						
	Pati Curi + Oller O.C.M.E. May 20, 2008					
16	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201					
State Registra	12 (4) /. 1 /1110 10 75 of a 12 / 12 / 12 / 12 / 12 / 12 / 12 / 12					

			State of Ma	ryland / Depa			lental Hygid	ene			
			Registrar Octimicate of Dea				Reg. No. 2 3. Time of Death 3. Time of Death				
Physician /Medical			Decedent's Name (First, Middle, Last)     CAROLINE	SPERMAN		Month MAY	Day Year		3. Time of Death 11:20 A M		
Examiner			4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	Death		
6			FOREST HILL HEALTH & REHAB (			REST HIL		E	LARF(	ORD	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 213-01-7466 1□ M ★□ F 92	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 30	rear)	Count	ace (State or Foreign try) yland	
Úv.	P.		Usual Residence of Decedent								
30	arylar show d at	Funeral Director	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Lim								
	ne Ma 8a-f s		Maryland Harford			ppa 	10g. Citizen of What Co.				
	with the lace of the notes		10e. Street and Number   10   10   10   10   10   10   10   1			10f. Zip Code 1 21085			at Count	,	
	leath ms 23 musi		11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. V				14. Race -	ace - American Indian,		
	be filed within 72 hours after death with the Maryland Hylgiene. Ad other than "natural", or Items 23a or 28a-f show event, the Me Ical Ex miner must be notified at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 △ No If Yes, Give	1 ☐ Yes 2 No Specify:			Rican, etc.)	Specific			
2-0036	hours tural										
<u>.</u>	nin 72  .m "ma Medic	plet	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)							,	
7	d with giene er tha the	To Be Completed	12 Years	' I	roll Cler	ck		C:	leri	cal	
_	0 = 0 %		17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname)			
yland	12 should be filed w h and Mental Hygie ? is marked other ti raumatic event, th		Phillip Vontran			Louise					
Mar	d 2 sh th and th sm 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  Mr. Louis M. Vesperman (Son		ig Address <i>(Street a</i> . Shore Di			, , ,	ate, Zip 1085	Code)	
a,	s 1 an f Heal Item 2 other		20a. Method of Disposition	20b. Place of Dispos		- i		0c. Location - C	ty or To	wn, State	
Ē	Page nent o int: If iry or		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Cemetery	· i	′2008 Ва	altimor	e, M	aryland	
baltimor	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 its marked any injury or other traumatic ev once.		21. Signature of Funeral Service Licensee	22	Name and Address Duda-Ruc	s of Facility Funeral	. Home of	Dundall	۲,	Inc.	
	20 = 60		7922 Wise Ave. Dundalk, Maryland 21222  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate								
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final								
1	/Medical		disease or condition resulting in death)  a. Due to (or as a consequent of):								
	Examiner		Sequentially list conditions b.								
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
e.	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a								
0/00	ficate be executed physician and s the burial-transit	dical	d								
0	certifica nding ph use as t	Med	IF FEMALE:								
X D D	eath co	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy				23d. Date of delivery  Month Day Year			
	the de y the		1 □ Yes 2 No 9 □ Unknown 4 □ Pregnant at time of death 5 □ Other (specify)						·		
, T	s that ined b e deta	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					. Did tobacco use contribute to the cause of death?			
ecords,	equire en sig ould b	ed b					1 ☐ Yes	3 2 No 3	☐ Prob	ably 4 Unknown	
ည်	The law requires that the death ate has been signed by the attenbage 2 should be detached for u	Completed			<u>-</u>		24a. Was an autopsy	pri	ere autop	osy findings available npletion of cause of	
	cate h	Con					perform 1 Yes 2	ed? de No 1	ath? ]Yes	2010	
N   C	Iclan certifi ector	Be	25. Was case referred to medical examiner?  Hospital:		A 311 DOA Othe	or 1	h (Check only one,				
5	Phys this ral dir	٦.	1 ☐ Yes 2 ☐ No ☐	·	1 3 DOA	4 Nursing H	ome 5 Residen			1)	
5	Attending Physician: r death. ector: After this certific. by the funeral director,	tion	1 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	Year) Injury	Worf	(? Yes 2 □ No	Zod. Describe flow	injury occurred	•		
INISIOI	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	ry - At home, farm, stre . <i>(Specify)</i>	eet, factory, office				l Route Number,		
5	ital ol rrs afte ral Di										
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, within 24 hours after death, to the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifler  (Check only one)  Certiflor 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certiflor 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Certiflor 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (	Month, i	Day, Year)	
			1 Day 5 D			2298		men 10	, 2	003	
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DAVID DUNN - 615 WEST MACPHAIL ROAD - BEL AIR, MD. 21014								
	Sta	te	Of D. C.	de Cierratura		AIN, MD.	21014				
	Registr	ar	MAY 2 1 2008	rs signature	w						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18 **Physician** ANCHE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death or Location of Death Examiner TIMORE ARE NURSING HOME 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace Country) (State or Foreign 5. Social Security Number Funeral Months Days Hours Min. 1 M 2 K -20-002 AND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2X No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ♣No Specify Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ЮRO ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ORLISS WAL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 3 ☐Removal from State 18€ Burial 2 ☐ Cremation WOODLAWN 4 ☐ Donation 5 ☐ Other (Specify) 21. Si nature o Funeral Service Licensee JR. 1-UNERAL 23a. x11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final sease or condition resulting in death) 6/20 Lesen ysician /Medical Due to (or as a conseque e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner alse Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Tonknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 TNo Be 25. Was case referred to medical examiner? 26. Place f Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural Iniury 5 ☐ Pending investigation

The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar Division or Vital Records, P.O. Box 68760, After this certificate has page 2 or Attending Physician: filled in by the funeral within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certiffe

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENTAW ST SMITE 300 BALTIMORE MD 2120 821 N A 31. Date filed (Month, Day, Year)

1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

2008

6 ☐ Could not be

determined



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

# Baltimore, Maryland 21215-0036

Box 68760,	
P.O.	
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on of Vita	
ivisi	

		For State Registrar	•			d / Depa		of He	alth and	Mental Hy		200	8 16	530
Physicia /Medic	an al	1. Decedent's Name (First, Mid Mary 4a. Facility Name (If not institut		et and numb	er)	U	00   4 4b. City, To		ocation of Death	2. Date of De Month	Day 10		3. Time of 11.30	Death A-M
Examin Funeral		The Johns Hopkin  5. Social Security Number	6. Sex	ital 7	. Age (In yrs. la	• • • • • • • • • • • • • • • • • • • •	Baltim If Under 1	ore (		. 8. Date of Bir	th ay, Year)	9. Bir	thplace (State or	r Foreign
Director		219-20-7218  Usual Residence of Decedent 10a. State 10b. Cour		2 💢 F	10c. City	Yrs.				08-31-	-1927		MD 10d. Inside Ci	ty Limits
ith the Mary or 28a-f sh e notified a	Director	MD Ba1  10e. Street and Number	timore		<u>Ba</u>	ltimo:	10f. Zip-C					zen of What Co	1 🗆 Yes	2X No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	8 Bothwell G  11. Marital Status  1 Never Married 2 MM 3 Widowed 4 Divorce	12.	Was Deced Armed Forc 1  Yes 2 If Yes, Give Year or Date					panic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	USA -	A 14. Race - Ame Black, Whit Specify: W	e, etc.	
within 72 hour ene. than "natural' ie Medical Ex	Completed b		ent's Educat nest grade co	ion		(Give life. I	dent's Usual kind of work DO NOT use etary	done du	ion ring most of wo	rking		ind of Business		
ould be filed Mental Hygi narked other atic event, th	To Be C	17. Father's Name (First, Middle John Parks		Drint		10b Maili	ne Addross /		Edith	me (First, Middle Albrigh ural Route Numi	t		Zin Code)	
s 1 and 2 sh f Health and frem 27 Is m other traum		19a. Informant's Name/Relation Preston Eugen 20a. Method of Disposition	e Wolle	ett(Hu	20b. Pl	8 Bo	_	.1 Ga	rth Bal	timore,	MD :			
ermit. Page: epartment o nportant: If in ny injury or		1 Burial 2 Cremation 4 Donation 5 Other 21. Signature of Fundal Service	(Specify)	oval from St	ale	dens	of Fai 2. Name and	th Address	5-20	-2008 himunek	Fune			
Physician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)		ACL		Do not ent	ter the mode	of dying				21236	Approximat Interval Bet Onset and I	ween
te be executed spician and spician and purial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c d		r as a consequ							· · · · · · · · · · · · · · · · · · ·		
The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c.	1 Live bir	ome of pregna th 2 Fetal nt at time of de	death 3	☐ Ectopic pre☐ Other (spec					23d. Date of do	,	Year
w requires that the death been signed by the atter should be detached for	by	Part ii. Other significant cond	itions contrit	outing to dea	ath but not resi	ulting in the	underlying ca	ause give	en in Part I.				to the cause of o	death? Unknown
rsiclan: The law rent continue to the continue	Completed										ormed?	prior to		available cause of
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	on: To Be	25. Was case referred to mediexaminer?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Per	Hos	28a. Date of		ER/Outpatier 28b. Time o Injury	of 28	Other c. Injury Work?	4 □ Nursing H	ath (Check only  Home 5 Res  28d. Describe	idence		ecify)	
To the Hospital or Attending Physical to the Hospital or Atter this To the Funeral Director: After this completely filled in by the funeral of	Certification:	3 Suicide 6 Cou	ermined	building	f injury - At ho g, etc. (Specify	)		office	es 2 No	City or To	wn, State,	)	Rural Route Nun	nber,
he Hospitz in 24 hours he Funeral spletely fille	Medical (	(check only 2 ☐ Medi one)	al Examine	an: To the base and manner	sis of examinat	vledge, deat ion and/or ir	nvestigation, i	in my op	inion, death occ	e, and due to th curred at the time	e, date an	nd place, and d	ue to the cause	(s)
To t with	M	29b. Signature and title of cer	ifier		M:17.		29c.	License	1344		290. Da	te signed (Mor	2 00 Z	<u></u>
12			nan,		of death (iten			o; ta	\ 600	North W	olfe S	t, Baltim	ore, MD,	21287
Sta Registi		31. Date filed (Month, Day, Yea	1 2.00	32. HG	jistrar's Signat	ure A	DEALL	,						

			For State Registrar	State of Ma	arylan		rtment <i>tificate</i>				/lental		iene eg. No.	008	18539
			Decedent's Name (First, Middle	e, Last)							2. Date	of Deat	th		3. Time of Death
	Physicia		George	Tho	mas		1	Wood	đ		Mon		Day	Year 2008	45 : 25 PM
1	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, 1	Town, or	Locatio	n of Death	1	1		nty of Deat	
7			Sinai Hospital	of Baltimore	2		Balti								
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. I	a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Und	er 24 Hrs. Min.	8. Date (Mor	of Birth th, Day,	Year)	9. Birt Co	hplace (State or Foreign untry)
	Director	ŀ	219-18-7257 Usual Residence of Decedent	X	82	115.					08	13	25		MD
	/land	ĺ	10a. State 10b. County		10c. City	y, Town or Loc	cation								10d. Inside City Limits
	Mar a-f st	ģ	MD	NA		Balt	imor	е							1 K∏ Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				1	0g. Citizen	of What Co	untry?
0.1	23a	Ta	3206 Leighton	n Ave				212	15				U.	S.A.	
hient bnown as Wood George Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rigitled at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 Mar 3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	Vas Deced fYes, spec I∐Yes 2	X No	Speci		pecify Yes Rican, e		Spe	Black, White	ack
2 to	"nat	lete	(Specify only highe	t's Education st grade completed)		16a. Deced	lent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>luring m</i>	ost of work	king	- 1	16b. Kind o	f Business/	Industry
352	withii iene. • than	mo	Elementary/Secondary (0-12) 1-2th grade	College (1-4or 5	i+)		Teac		,				Balt	imor	e City
2 pt	il Hyg other /ent,	BeC	17. Father's Name (First, Middle,						18. Mo	ther's Nam	e (First, I	Aiddle, I	Maiden Suri		
<u>a</u> ≥	Vienta Vienta rked	10 E	Albert Mauri	ce Wood				1	Mađ	elin	e 0]	.ive	er		
د ا	and hard is ma		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address	(Street a	and Nun	nber or Ru	rai Route	Numbe	r, City or To	wn, State, Z	Zip Code)
Prown	and and m 27		Lorraine M W	ood-Wife									nore,		21215
ore le	ges 1 If of H If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State		lace of Dispo emetery, cren					Date			,	Town, State
₽ij	t. Pag rtmen rtant; rjury		4 ☐ Donation 5 ☐ Other (S	pecify)	Met	ro Cr			- '		17/0	)8   E	Balti	more	, Md
Poshent Baltin	Depar Impor any Ir once.		21. Signature of Funeral Service	March		Ma 43	Name and CO W	F/H aba	we we sh	st. Ave,	Bal	tin	nore,	Md	21215
() meles			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death	n. Do not ent	er the mode	e of dying	g, such	as cardiac	or respira	tory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Intracr	anial	hemo	rrhag	e							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as											
		in in	Sequentially list conditions, If any leading to home date  Metastatic carainaid tumor  Due to (or no a consequence of).											20 years	
	uted 1 Insit	Examiner	if any, leading to him-ediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
Ć.	exec an and ial-tra	Еха	resulting in death) Last	c Due to (or as	a consequ	uence of):									<del></del>
68760,	ficate be executed physician and s the burial-transit	edical		d											
_		Medi	IF FEMALE:											1111	
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pr	regnancy	v				23d.	Date of del	,
	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (sp					_		Month	Day Year
P.0	res that the de signed by the a be detached t	Phy	Part II. Other significant conditi	ons contributing to death b	ut not rec	ulting in the ur	nderlying ca	use aive	an in Pai	rt I	236	Did to	hacco use o	contribute to	the cause of death?
ds,	signe d be c	d by	Chronic kidner	1.	ut not rest	alang in the di	idenying co	iuse give	>11 111 t Q1		200				robably 4 \ Unknown
Sor	w requir	etec	4.4					-			04-	. Was a	- 10	45 W	
Re	he lav e has ge 2	Completed	- Hypertentian								240	autops	sv	prior to death?	utopsy findings available completion of cause of
tal	sician: The law certificate has birector, page 2 sl		25. Was case referred to medica						ae Ble	ace of Dea			med? 2 No	1 □ Yes	2 🖺 No
<u> </u>	ystcia is cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗍	ER/Outpatier	nt 3 🗆 DO	A Othe					ence 6 🗆	Other (Sne	ecify)
Division of Vital Records,	ding Physician: The h. After this certificate h. funeral director, page	Certification: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time of Injury		Bc. Injury Work		rvaronigiri			ow injury oc		.ony)
io	Attendin death. ctor; Af y the fur	atio	1 Natural 5 Pendir investi	gation	y, rour)	,,	М		Yes 2	□No					
iž	r Att ter de irecto	₩	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		ury - At ho c. <i>(Sp</i> ec <i>if</i> )	ome, farm, str	eet, factory,	office			28f. Loca City	ation (S. or Tow	treet and No	umber or Ri	ural Route Number,
Ω	urs at urs at illed i		00 0 0 0												
	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best Examiner: On the basis of and manner st	of examina	wiedge, deati	n occurred vestigation,	at the tin in my o	ne, date pinion, d	and place death occu	e, and due irred at the	to the o	date and pla	d manner a	s stated. e to the cause(s)
	To 1	Σ	29b. Signature and title of certifie					. License				2	29d. Date si	gned (Mont	th, Day, Year)
	2		VanaPaur	an i			(	2E5	- 0	00			May	13 2	2008
	7 1		30. Name and address of person	who completed cause of c	leath (Item	23a) (Type,	Print)	hall	·				,		
	Sta	to	31. Date filed (Month, Day, Year)	MD Gina	ar's Signa	ture /	01		~ mo	re					
	Registra	ar	31. Date filed (Month, Day, Year) MAY 2 1 20	08	15.	1 23a) (Type, Xpital ture	1								

State

HILDA WILLIAMS

Registrar

DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. ERNESTINE WRIGHT

31. Date filed (Month, Day, Year)

			_ ror	State of Maryland				lental Hygi	ene and	10 [65]	. ]
		_	State Registrer		Certi	ficate of L	Death	Re 2. Date of Deatl	g. No.	3. Time of Deal	† [
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) ALTRED	111	EIRS			Month /	9 Day 200	(ear, 11:40)	4 M
1	Examin		4a. Facility Name (If not institution, give str BALTI MUNE RELTABILITA			lb. City, Town, or BA	Location of Death	RE	4c. County of	Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or For Country)	reign
	Director		131-07-7680	<sup>1 2□F</sup> 90	Yrs.	WOIIIIS Days	Tiours Ivian.	03 03	18	MD	
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Lir	mits
	Mary 1-1 sh	tor	MD NA	Ba	ltimo	re				Yes 2	] No
	or 28	Director	10e. Street and Number			10f. Zip Code	215	10	og. Citizen of Wi	nal Country?	
	death with the Maryland me 23e or 28a-f show	eral	6317 Park Height	ts Ave Apt  . Was Decedent Ever in U.S.			215 lispanic Origin? (So	ecify Yes or No-		- American Indian,	
	fter de	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.	
ğ	hours after ture!', or ite	þ	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give** Year or Dates:	1	Yes X No	Specify:		Specify:	Black	
1215-0036	"natu	Completed	15. Decedent's Educa (Specify only highest grade o	completed)	16a. Deceder (Give kir life. DC	nt's Usual Occup nd of work done of NOT use retired	ation during most of work d)	king	16b. Kind of Bus	iness/Industry	
_	i within 72 liene. r then "na!	dmo	12th grade	College (1-4or 5+)		stal Ca			Post	Office	
2	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene.  Is marked other then "naturel, or lieme 23a or 28a-1 show atmatic event, I'm Maulical Examinar must be notified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame	)	
Maryland	should be nd Mental marked o umatic eve	To	Alfred Barnett A			/2		n B. Ma		The Code (	
Mar	s 1 and 2 should I Health and Mer Item 27 Ie marke other traumatic		19a. Informant's Name/Relationship (Types Valerie Craig-Da	and the second second			and Number or Ru eights 1				Md
	s 1 and if Health item 27 other tr		20a. Method of Disposition	20b. Pla	ce of Disposit		- !			City or Town, State	
Ē	Pages nent of nnt: If it ury or o		Burial 2 Cremation 3 Rer	moval from State	-	•		/27/08	Owings	Mills, Mc	£
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		27. Signal re of Funeral Service Licensee	Sugar	Ma 43	name and Addre	ss of Facility H West ash Ave	, Balti	more,	Md 21215	
			23a. Part . Enter the disease, or complica shock, or heart failure. List only one	alions that caused the death.						Approximate Interval Between Onset and Deat	
1	Physician		mmediate Cause (Final disease or condition	CHRONIC OBST	TRUCTI	VEPUL	MONARY	DISEF	HE	6 year	
	/Medical Examiner		resulting in death)	Due lo (or as a conseque	ence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):						
	cuted nd ransit	Examiner	that initiated events								_
760,	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):						
387	physicate t	dlcal	d.								
ŏ	n certif	n/Me	IF FEMALÉ: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnand 1 Live birth 2 ☐ Fetal of		etopic pregnanc	v			of delivery	
P.O. Box 68	the death y the ette	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of dea		Other (specify) _	,		Mon	th Day Year	r
	Attending Physician: The law requires that the death certificate be executed rideath. If death. ector: After this certificete hes been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Pt	Part II. Other significant conditions conti	ributing to death but not result	ting in the und	derlying cause gr	ven in Part I.		_	bute to the cause of deat 3 ☐ Probably 4 ∭Unki	
00	s beer s shou	olete	CORONARY ART	TERY DISE	ASE			24a. Was a	n 24b. W	Vere autopsy findings ava	ilable
Ä	The It	mo						perfor	ned? d	eath? ☐ Yes 2☐ No	
/ita	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		0"		ith (Check only or			
of	Physical direction	- To	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Unpatient 2 UE	R/Outpatient 28b. Time of	3□ DOA 28c. Inju	4 (A) Nursing H	lome 5 Resid			
on	nding ith. :: Afte	atlon	1 Najural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2 □No				
Division of Vital Records,	or Atterded	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		er or Rural Route Number	,
	To the Hospital or Attending Physician: The I within 24 hours effer death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page	edlcal C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Exemina	icien: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the ti estigation, in my	ime, date and place opinion, death occu	o, and due to the d irred at the time, o	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)	
	within To the compli	Me	29b. Signature and title of certifier	1 01.	M	29c. Licen	se number	Á	29d. Date signed	(Month, Day, Year)	
	<		turon C.	lan, M.	U,	D14	1958	/\	MY 19	1,2008	
1	41		30. Name and address of person who con	noleted cause of death (Item	23a) (Type, P	Print)	RE M	17 21:	218		
Š	St	ate	31. Date filed (Month, Day, Year)	32, Registrar's Signati	ure A	alle B	10	010			
	Regist	rar	MAY 2 1 200	Just Hathar State	and the same						

18-	n3	73	2

Wayne Edward Wi	olls		a <b>se iyp</b> St	ate of Ma	ryland	Depa	rtment of	Health	n and	Mental	Hygie	ene		20	FIR	1654
	D.	For State egistrar				Cer	tificate of	Death			2. D	Reg ate of Death	No.	60 V	3. Time o	
Physician Modical Examine		. Decedent's Name Wa			Wolls	chlag	ger Sr.				Ma	onth ay 16, 200	)8	Year	0710	hrs
4		a. Facility Name (if			and number)		1	b. City, To Glen E		ocation of De	eath			nty of Deatl Arundel		
		Route 10 SDI		6. Sex	7. Aq	e (In yrs. la	ast birthday)	If Unde		If Under 24	Hrs. 8.	Date of Birth	(MM/DD/Y	YYY) 9. Bi	rthplace (S	tate or
Funeral Director		213 52 410		1 XM 2	"	57	Yrs	Months.	Days	Hours	Min.	June 6 :	1950	Forei	ountry) Mai	vland
	. L	Isual Residence of														de City Limits
w any	- 1		10b. County				Town or Locat	ion								es 2 No
yland yland once.	<u> </u>	Maryland  10e. Street and Num	Baltimo	те		MIT	te Marsh	10f. Zip	Code			10	g. Citizen o	of What Cou	untry?	x
or 28s	인	5600 Carrin		rive				2116	32			_   ,	ISA			
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner, must be notified at once.		11. Marital Status		12. W	as Deceden		.S. 13. Wa	s Decede	nt of Hisp	anic Origin? Mexican, Pu	(Specify Jerto Rica	y Yes or No- an, etc.)		Race - Ame White, etc.	erican India	n, Black,
death or iter	Funeral	1 Never Marrie		1XX	Yes 2	No		Yes 2					Spec	cify: Wh:	ite	
rs after ural", miner		Widowed  15. Decedent's Ed		vorced If Yes, 0 or Date ecify only high	S'	mpleted)	16a. Decede	nt's Usual	Occupation	on (Give kind	d of work	done		of Business		
72 hou n "nat	-   §	Elementary/Seco		Co	llege (1-4 or					DO NOT use	e retirea)				sone.	
5-0036 iled within 72 Hygiene. I other than the Medical	Completed by	12			V/A 		ITUCK	Drive		8. Mother's N	Name (Fir	st, Middle, M		king Ir name)	ndustr	У
215-( 215-( be filed a ntal Hygi rked oth	Be	17. Father's Name Donald W W							1,	larriet.	te V.	Bethou	11e			
212 ould be ould be is mark	ᆰ	19a. Informant's Na										Route Num			ate, Zip Co	de)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once		Paul S. W		Lager (Bi	rother)	20b.	9915 Place of Dispo					re Mary ate	land 2°	1234 ation - City	or Town, S	tate
Ore, ges I an of Hea If ite		1 Burial 2	Crematic	on 3 Rer	noval from S	tate	crematory or	ther place	)		0		Poltás	more.Ma		_
Itim it. Pag urtment ortant:		4 Donation 5	Other :	Specify: • U censee		l l a				of Facility ral Home			Гратил	iore.w	ar A Tai i	
Ba perm Depg Imp	1	23a. Part I. Enter th		Berth in				assann 101 Bo	rune: lair [	raı Hom Poad <del>Ba</del>	e inc <del>ltimo</del>	ne Mary	Land 2	1236.	Appn	oximate Interval
Physician 'Medical		23a. Part I. Enter the failure. List or	he disease, only one caus	e on each mic			h, Do not enter	the mode	of ying,	such as car	OBJE OF TE	Spiratory and	ust, urrown,	STREET		een Onset and Death
viedical.	- 1	Immediate Cause or condition resulti			ole Injurie		of):								+-	
		Sequentially list co	onditions,	b												
	ije	if any, leading to in cause. Enter Und	mmediate erlying Caus	e .	(or as a con	sequence	of):									
J. H.	Examine	(Disease or injury events resulting in		Due to	(or as a cor	sequence	of):								· ·	
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Box 68760, e death certificate be the attending physic ed for use as the burned for the burned for use as the	ysic	1 Yes 2		Inknown 9	Unknown							100 Pidd	- b	a contribute	o to the car	use of death?
cords, P.O. Bo: law requires that the deatl has been signed by the an should be detached for	by Pr	Part II. Other sign	nificant con	ditions contr	ibuting to de	ath but not	t resulting in the	e underlyir	ng cause	given in Pari	t I.					4 Unknown
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cord law rec has be	Completed	N											psy ormed? 2 No	deat		tion of cause of
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should I		25. Was case refe	erred to med	ical					26.Plac	e of Death (	Check on					
Vital ysician his cert directo	o Be	examiner?	2 No	Hospit	al: 1 Inpa	atient 2	ER/Outpation	ent 3	DOA			Home 5		ce 6 🗸 C	other: Scen	e
of Ning Ph	n:	27. Manner of De	ath	2	8a. Date of (Month, Da May 16, 20	Injury ex Year)	28b. Time 6	of Injury		uryat Work? Yes 2♥	ln	8d. Describe Priver of a	to invol	ved in co	ollision	
Sion Mtend death. ctor;	catio	1 Natural 2 Accident		Citation			t home, farm, s	treet, facto						Number c	or Rural Ro	ute Number, City
Divis pital or At ours after d teral Direc	Certification: To	3 Suicide 4 Homicide	d	ould not be			oad / Highw					or Town, Coute 10 so	State) uth bound	i at exit 1,	, Glen Bu	rnie, MD
E 6 5.		20a Cortifier					edge, death oc n and/or invest	aumod at t	he time, o	date and pla	ce, and d	lue to the ca the time, dat	use(s) and e and place	manner as e, and due	stated. to the caus	se(s)
To the Hos within 24 h To the Fun	Medical	one) 2 2 29b. Signature ar		and	manner stat	ed.				ise number				ate signed		
	2	205. Signature ai		21/	1/2				0.0	.M.E.			May	16, 2008	3	
, ,		30. Name and ad		son who comp	lete cause	of death (If	tem 23a)			altinen==	MD 241	201				
10+1		Jack Titus		Deputy Chie	100	I Examir strar's Sigr		enn Str	eet, Ba	altimore, I	IVID 212		<del> </del>			
St Regis	tate tra	- 17	ontn, Day Ye	1 2008	32 aregi	148 F	B. A	arth						OCME		
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08-03705 Fr

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rank Whitehead	1	State of Maryland / [ -For State	Department of Certificate of	Health and Men Death	tal Hygiene Reg.	No. 2009	1 5 5 1			
Physicia		legistrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death	3. Time of D				
Medical Exami ≿∴		FRANK DOUGLAS WHITEHEAD S		b. City, Town, or Location	Month D May 15, 200	8 U934 III	S			
		4a. Facility Name (if not institution, give street and number)  St. Agnes Hospital		Baltimore	57 5566.	N/A				
Funeral Director		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) 59 Yrs	Months Days Hours		MM/DD/YYYYY 9. Birthplace (State Foreign Country)(ARY	i i			
япу	F	Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Locati	on		10d. Inside	City Limits			
<u>*</u> .	2	MD. N/A	BALTIMO	RE		1 XYes	2 No			
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?				
th the 23a or		1631 PARKMAN AVE.  11. Marital Status 12. Was Decedent Ev		21230 s Decedent of Hispanic Ori	gin2 ( Specify Yes or No-	14. Race - American Indian, E	Black.			
eath wi	Funeral	1 Never Married 2 Married Armed Forces?		es, specify Cuban, Mexicar		White, etc.				
after d	by Fi	3 Widowed 4 X Divorced If Yes, Give Yeer or Dates:	1	Yes 2 No specify		Specify: BLACK				
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin		15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+	during m	t's Usual Occupation (Give ost of working life. DO NOT		6b. Kind of Business/Industry	1			
36 hin 72 e. than "	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+ -6-		GRAM MANAGER		DEPT OF ENVIRONMENT				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name (First, Middle, Last) DAVID W. WHITEHEAD			r's Name (First, Middle, Ma DUISE JACKSON	iden Surname)				
5 9 9 E 3	o Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailin			er, City or Town, State, Zip Code)				
sho and 7 is	ř	LORRAINE ANDERSON (COMPAN	ION) 7 A	ACKERMAN CT.	STEVENSVILLE	E, MARYLAND 2166				
re, N I and FHealt Fitem er trau		20a. Method of Disposition  1 Burial 2 A Cremation 3 Removal from State		sition (Name of cemetery, her place)	Date	20c. Location - City or Town, State				
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation & Other Specify:	METRO CREN	MATORY	5-19-2008	BALTIMORE, MARY	LAND			
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun		21. Simpling of Funeral Service Licensee JONAT HAN								
Physician		23e Part I. Enter the disease, or complications that caused th	e death. Do not enter t	he mode of dying, such as	cardiac or respiratory arres	TIMORE MARYLAND t, shock, or heart Approxim	ate Interval Onset and			
Medical 'xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic C	ardiovascular Dis	sease			eath			
, Kallilloi		fracondition resulting in death)  Due to (or as a consequence)	uence of):							
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence)	uence of):							
₩ _	Examiner	(Disease or injury that initiated events resulting in death) Last	uence of):							
xecuted	Ē	d								
be esticiar	edical	UNPENDED AMENDED				23d. Date of delivery				
8761 tificate ng phy as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 Live birth		etal death 3 Ector	oic pregnancy	Month Day	Year			
Box 6876 death certificat the attending phy ed for use as the	Physician/W	1 Yes 2 No 9 Unknown 9 Unknown	me of death 5 0	ther (Specify)						
. 2 . 2			but not resulting in the	underlying cause given in F	Part I. 23e. Did tob	pacco use contribute to the cause of				
, P.O. res that the signed by	d by				1 Yes					
ords, P w requires t as been signs should be d	olete				24a. Was a autops	y prior to completion of	gs available of cause of			
Rec The lar cate ha	Completed				perform 1 ✓ Yes 2		No			
Division of Vital Records, tal or Attending Physician: The law requinrs after death.  The Director: After this certificate has been sited in by the funeral director, page 2 should 1	Be	25. Was case referred to medical examiner? Hospital: 1 Innation	t 2 🗸 ER/Outpatier	Othor	h (Check only one)  Nursing Home 5 F	Residence 6 Other:				
n of Vi ding Physi 1. After this funeral dii	요 ::	1 ✓ Yes 2 No 1 inpatient  27. Manner of Death 28a. Date of Injur (Month, Day, Ye		0 56.1		ow injury occurred				
OD Conding sath.	tion	Natural 5 Pending	ar)	1 Yes 2	No					
Divisior tal or Attenders after death	Certification:	Suicide Could not be	ury - At home, farm, str	eet, factory, office building,	etc. 28f. Location (S or Town, St	treet and Number or Rural Route N ate)	lumber, City			
Division  Hospital or Attent 24 hours after death Funeral Director:										
Di To the Hospital o within 24 hours a To the Funeral K	Medical	one) 2 Medical Examiner: On the basis of exam	ination and/or investig	ation, in my opinion, death	occurred at the time, date a	and place, and due to the cause(s)				
To To	Mec	and manner stated.  29b Signature and title of certifier		29c. License numbe	er	29d. Date signed (Month, Day, Ye	ar)			
		tatia - Hele	10	O.C.M.E.		May 16, 2008				
10+1		30. Name and address of person who completed cause of de Patricia Aronica-Pollak MD. Assistant M	eath (Item 23a) edical Examiner	111 Penn Street F	Baltimore, MD 21201					
	tate	31. Date filed (Month, Day, Year) 32. Registrar		)						
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Joan Ward May 20. 2008 9:00 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 310 Greenway Harford Bel Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1 □ M 2 □ XF Sept. 9, 1932 Washington, DC 214-32-8102 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show be notified at 1 ☐ Yes 2 No Director Maryland | Harferd Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 310 Greenway 21014 **USA** 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Exa<u>miner must</u> Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 Specify <u>م</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Althea (nmn) Arceneaux Samuel Byron Eccles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick Ward / Husband 310 Greenway, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on eart line. Immediate Cause (Final disease or conditions) Immediate Cause (Final disease or condition resulting in death) **Physician** 1 WK /Medical Due to ( r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and a Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours a er death. uneral Director: A 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated

7

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

Harapanahalli,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 Atwood Road, Suite 207, Bel Air, MD 21014

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1112PM Day Year **Physician** PAUL WOODROW WRIGHT 2008 /Medical 4a Facility Name (If not institution, give street and number) Çity, Town, or Location of Death 4c. County of Death Examiner Hartoro (5100 Year 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 XM 2 □ F Director 223-28-5561 86 Sep. 4, 1921 Virgínia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 150 Bay Blvd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify. 1 ☐ Yes 2 No Specify. 3 □ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) Coilege (1-4or 5+) Auto Sales 10 Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked oth Be Fred (nmn) Wright Mazy Florence Combs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Bay Blvd., Havre de Grace, Maryland 21078 Hazel Dean Wright / Wife other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Grdn 5-19-08 Aberdeen, Maryland 21. Signature of Fuperal Service Licenses McComas Actess of Fairly Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical of (or as a consequence of): Examiner Knamers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page 2 2 No 1☐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Surring Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3□ DOA 1 | Inpatient n by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manper of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the

State Registrar 29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day,

Year)

f person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

16

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Williams **Physician** /Medical 4b. City Jown, or Location of Death 4a. Facility Name (If not institution give street and number) Examiner dallstown ranchieles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign st birthday) **Funeral** Months 12M 2 F Days Hours Min ra Director Usual Residence of Decedent 10c. City, Town or Location 0d. Inside City Limits 10b. Count 28a-f show at 1 des 2 No : If Item 27 is marked other than "natural", or Items 23a or 28a-f sh or other traumatic event, the Medical Examiner must be notified. Director yaryland 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1100 . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 D If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 is marked other than "natural", or 1 ☐ Yes 2 No 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Operator (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other transcript 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be Kessle Jones 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode Immediate Cause (Final **Physician** Almerorcheso disease or condition resulting in death) weaks /Medical Due to (or as a consequence of): Examiner eas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execute burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ned by the atter in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? bate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 4 ☐Unknown 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2**□**/No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Medical Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Rolling

cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Yancura Thelma Η. May 2008 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Co. Pear Tree Assisted Living Ctr. Severna Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Year Hours Months Days 1 □ M 243x F 88 Director 412-16-5755 Tennessee April 3,1920 Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8001 Middlebury Drive United States 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ğ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Its Ma Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas Electric Salesperson 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thursie Morton 2 Albert T. Hammond, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, Maryland 21122 308 Tennessee Ave. (Daughter) Patricia Spratley 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 5/19/2008 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) VPq **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 3 No 1 ☐Yes 2 100 1 Tyes Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 General (Specify) 1 ☐ Yes 2 17N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Di atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours aft the Funeral Di npletely filled ir 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the To the Within 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) GIZ 32 Registrar's Signature State 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19 MAY 2008 LILLIAN ZESKIND 6:40A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RUXTON OF PIKESVILLE HEALTH CTR. PIKESVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 6. Sex **Funeral** 1 □ M 2X F Days (Month, Day, Year) 07/02/1915 Hours Director 220-03-0058 92 Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2702-C JEREMY COURT 21209 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No WHITE Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) HOCHSCHILD-KOHN Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORE SALESPERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev MYER ZESKIND EUNICE ABRAMOWITZ ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD MEKILIESKY / NEPHEW 15 MANSEL DRIVE, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ANSHE SFARD 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 05/20/2008 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, N 21. Signature of Funeral Service Licenses 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician by Physician/Medical use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 Z No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy page performed certificate or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 44 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide determined filled To the Hospital 1 ី certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

1

Registrar

31. Date filed (Month, Day, Year) MAY 21

. Zibelt

29b. Signature and title of certifier

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

29c. License number

037573

Reisterstown

29d. Date signed (Month, Day, Year)

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	2 %		Registrar	dia Loot)		Cei	lilicate of i	Dealli	2. Date of Dea	Reg. No.	UUC	3. Time of Death
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	/Medic		Edna  4a. Facility Name (If not institution		Allen_		4b. City, Town, or	L coation of Doot	May 6,		y of Death	4:07 a ™
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	Francis .		5. Social Security Number		Age (In yrs. I	ast birthday)		If Under 24 Hrs	8 Date of Birt	h	9. Birthp	lace (State or Foreign
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	er de items	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	S.   13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)	BI	ack, White,	
36	rs aft I', or kamil	by F	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	7.11		1 ∐ Yes 2√2 No	Specify:		Spec	ify:	hite
<del>o</del>	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	pa	15. Decede	ent's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of		
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To	John H		is			Lu		Long		
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			30. Name and address of person Mary Kramer				Print) rive, Cha	rlotte F	Iall. MD	20622		
	Sta	te		THE STATE OF THE S	gistrar's Sign	D 4			,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5, MAY 2008 11:00 A M **GEORGE** Η. ANGLEBERGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Walkersville Frederick Kenwood Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 XM 2 □ F July 19,1924 Maryland 219-20-1053 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner with the Medic 10d Inside City Limits 10c. City, Town or Location 1X Yes 2 No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 300 Kenwood 21793 Court States United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Whipp Angleberger Hilda P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret M. Angleberger / Wife 300 Kenwood Ct./ Walkersville, MD 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State May 12, 2008 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediat Cause (Final disease or condition resulting in death)

a. Distriction of the condition resulting in death) 1621 Opossumtown Pike/ Frederick, MD Approximate Interval Between Onset and Death navs **Physician** /Medical as a consequence of): Examiner tastate colon Saquandaily liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) physician a s the burial-Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
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4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by acheria 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Di

completely filled in 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A. Z HEGAZI, ans MD 46 B T. Johnson Dure Frederich MO 21762 Name and address of person who completed cause of death (Item 23a) (Type, Print) HEGHZI State

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Registrar

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Division

			1 - For State Registrar	State of Mary	and / Depa	artment of H	lealth and Death		ene200	8 16551
	L		Decedent's Name (First, Middle, Last,					2. Date of Death	1	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Security Number 15. Security Number 1	7. Age (In 81	yrs. last birthday) Yrs,	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day, Feb. 1,	9. E 1927 Ma	Birthplece (State or Foreign Country) aryland
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mentat Hygiene. Department of Heath and Mentat Hygiene. Important: If time ZT is marked other then "naturel; or items 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	10a. State 10b. County  Maryland Washin  10e. Street and Number  154 Artizan Street  11. Marital Status	gton		Williamsp 10f. Zip Code 2	1795	? (Specify Yes or No- uerto Rican, etc.)		nerican Indian,
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kamin		4a. Facility Name (If not institution		nber)	4b. City	, Town, or l	Location of		., _,,		unty of Deat	
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eral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last bii	Months	Days	If Under 2 Hours	Min.	ate of Birth Month, Day	, Year)	9. Birti Co	hplace (State or Foreig untry)
or		578-58-8324 Usual Residence of Decedent		63	Yrs.			11	/29/1	1944	Was	hington
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	to	Maryland Prince	e George's	Capit	al Heig	hts						1 <sub>√</sub> Yes 2 No
	Funeral Director	10e. Street and Number			10f. Zi	p Code				0g. Citizer	of What Co	untry?
	a	4312 Vine Stree	et			20743			1	Unite	d Stat	es
9	2	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S.	13. Was Dece If Yes, spe	edent of His	panic Orig	in? (Specify , Puerto Rica	Yes or No- n, etc.)	14.	Race - Ame Black, White	
Ü	S C	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Yes, Giv	re	1 🗆 Yes		Specify:			j	ecifyB1a	ck
-	Da Da	15. Deceden	Year or D		. Decedent's Ust	ial Occupat	tion			16b Kind	of Business/	Industry
	piet	(Specify only highes	st grade completed)		(Give kind of wi	ork done du	iring most	of working		TOD. KING	01 003111633	industry
	Completed	Elementary/Secondary (0-12)	College (1		ainter					D C G	overn	ment
	Bec	17. Father's Name (First, Middle,	Last)			1	18. Mother	r's Name (Fir				
	ToE	Edward Smith				M	Matti	e Mild	red B	ut1er		
		19a. Informant's Name/Relations	hip (Type, Print)	198	o. Mailing Addres	s (Street ar	nd Numbe	r or Rural Ro	ute Numbe	r, City or To	own, State, Z	lip Code)
		Kim M. Butler /	Daughter		00 Snow		oad L		Mary			
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	cometa	of Disposition (Na ery, crematory or	ime of other place,	)	Date		20c. Locat	ion - City or	Town, State
ı		4 □ Donation 5 □ Other (S		Harmon	y Memori			/8/200				Maryland
		21. Signature of Funeral Service	(())(7)					Pope F				
İ		23a. Part1. Enter the disease,	complications that a	auged the death. De							Mary.	Land 20747 Approximate
l		shock, or heart failure. List	only one cause on e	ach line.	not enter the mo	de or dying,	, such as t	Sardiac or res	piratory arr	est,		Interval Between Onset and Death
ı	1	disease or condition resulting in death)		C SHOCK								
ı		,		or as a consequence						,	mes.	
	ē	Sequentially list conditions. if any, leading to immediate		PLE DECUBI or as a consequence				^	M	ON EXAM	WEE.	
ĺ	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PERST	STANT VEGE	TATIVE S	STATE		120	VED BY MET	JKHL -		
ĺ		resulting in death) Last		or as a consequence		,		CHAIN	,			
١	-1						CEKIII.					
	Ca		d									
	Medica	IF FEMALE:	d									
	lan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live b	come of pregnancy irth 2 □ Fetal death		pregnancy				-11	. Date of deli	
	/sician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live b	irth 2 ☐ Fetal death ant at time of death	3 □Ectopic p 5 □ Other (s	pregnancy				-11		ivery Day Year
	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno	irth 2 ☐ Fetal death ant at time of death own	5 Other (s	pregnancy pecify)				23d	. Date of deli Month	Day Year
	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno	irth 2 ☐ Fetal death ant at time of death own	5 Other (s	pregnancy pecify)				23d	. Date of deli Month contribute to	Day Year the cause of death?
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	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b 4 ☐ Pregn 9 ☐ Unkno	irth 2 ☐ Fetal death ant at time of death own	5 Other (s	pregnancy pecify)			23e. Did to 1 ☐ Y 24a. Was a	bacco use	Date of deliments.  Date of deliments.  Date of deliments.	Day Year the cause of death?
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	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition  25. Was case referred to medicate examiner?	1 Live b 4 Pregn 9 Unkno	irth 2 ☐ Fetal déath ant at time of death own path but not resulting in	5 ☐ Other (s	oregnancy pecify) cause given	n in Part I.	of Death   Ch	23e. Did to 1  Yes 24a. Was a autop: perfor I Yes eck only or	23d bacco use es 2 \( \sigma \) in 2 y med? No	Date of delimenth Month  contribute to lo 3 pri 4b. Were au prior to death? 1 Yes	the cause of death?  obably 4 TUnknown  topsy findings available completion of cause of
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	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medicate examiner?  1   X es 2   No    27. Manner of Death 1   Natural   5   Pendin investic investic   3   Suicide   6   Could referred to medicate   4   Homicide   1   Certifyin    29a. Certifier   1   Certifyin   (Check duly one)   2   Medical	Hospital:    Hospital: 1   II   II   II   II   II   II   II	inth 2 ☐ Fetal death and at time of death with an at time of death with a state of the state of	5 Other (s	OA Cther Work?  1 Ye, office	26. Place 4 \( \) Nur  at 2 \( \) Nur  at 2 \( \) Nur  at 3 \( \)	of Death Chrising Home 28d. No 28f. L	23e. Did to  1  Yes 24a. Was a autop: perfor 1  Yes eck only or 5  Resid Describe h cocation (S	23d bacco use es 2 N in 2 sy sy med? 2½No rel ence 6 on, State) ause(s) an ate and pia	Date of deliments  Contribute to the second of the second	the cause of death?  obably 4 Dunknown  topsy findings available  completion of cause of  which is a second completion of cause o
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	Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medicate examiner?  1   X es 2   No    27. Manner of Death  1   Natural   5   Pendin investig    2   Accident   3   Suicide   6   Could referred to medicate    4   Homicide   1   Certifyin    29a. Certifier   1   Certifyin    (Check only one)   2   Medicate    29b. Signature and title of certifier	Hospital:    Hospital: 1   In	inth 2 ☐ Fetal death and at time of death and at time of death own bath but not resulting in the patient 2 ☑ ER/Out of Injury At home, fang, etc. (Specify)  best of my knowledge asis of examination and are stated.	other (s	OA Cther Work?  1 Ye, office	26. Place  4 Nur at es 2 N es acte and non, deate	of Death Chrising Home 28d. No 28f. L	23e. Did to  1  Yes 24a. Was a autop: perfor 1  Yes eck only or 5  Resid Describe h cocation (S	23d bacco use es 2 N in 2 sy sy med? 2½No rel ence 6 on, State) ause(s) an ate and pia	Date of deliments  Contribute to the second of the second	the cause of death?  obably 4 Dunknown  topsy findings available  completion of cause of  which is a second completion of cause o
	Medical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medicate examiner?  1   X es 2   No    27. Manner of Death 1   Natural   5   Pendin investic investic   3   Suicide   6   Could referred to medicate   4   Homicide   1   Certifyin    29a. Certifier   1   Certifyin   (Check duly one)   2   Medical	Hospital:    Hospital: 1   In the local patient of the patient of	inth 2 ☐ Fetal death and at time of death and at time of death own bath but not resulting in the patient 2 ☑ ER/Out of Injury At home, fang, etc. (Specify)  best of my knowledge asis of examination and are stated.	other (s, n) the underlying of the underlying of Injury M arm, street, factor and occurred to occurred	OA Cther OA	26. Place  26. Place  4 \( \text{Nur} \)  at  es 2 \( \text{Nu} \)  by date and nuon, deatt  number	of Death   Ch rsing Home 28d. No 28f. L d place, and d n occurred at	23e. Did to  1  Yes 24a. Was a autoproperfor Yes eck only or 5  Resid Describe h .ocation (S .ocation	bacco use es 2 No sy med? 22 No re ence 6 output treet and No n, State) ause(s) an ause and pia	Date of delimination of the Month  Contribute to the death?  1 Yes  Courred	the cause of death?  obably 4 Dunknown  topsy findings available  completion of cause of  which is a second completion of cause o

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene: Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 05 /Medical 4c. County of Death 164 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomer Germantoun GAYden Dr. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Mooth, Day
7 35) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 465-96-836 1 M 2□F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Mont Director NON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #104 20 SA 18053 GAYden by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed er than "natura the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) International Consul 17. Father's Name (First, Middle, Last) Be ျှ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If Item 27 Is m any Injury or other traum once. stal JAF ct. 861 Germaniousn Mi) 20870 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation National Mers. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 1242 Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any language immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 □ No 3 Probably 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performe certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28b. Time of I Director: After to d in by the funeral 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral DI

completely filled in Notes the cause (s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

and title of certific

MAY 0 8 ZUUS

address of person who cor

29b. Signa

GENEVIEVE WROBLEWSKI 32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician <u>4:</u>35 a<sup>M</sup> 4, 2008 May James Douglas Butler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lexington Park St. Mary's 23160 Gunston Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1**X** M 2□ F Yrs. North Carolina 70 02/03/1938 Director 241-52-8164 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2 X No Director Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or United States items 23a 20653 an "natural", or Items 23a Medical Examiner must 23160 Gunston\_Drive 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. the Technical Trainer Defense Contractor 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Walter Butler Winell Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 23160 Gunston Drive, Lexington Park, MD 20653 Sandra Butler/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Episcopal Cem 05/08/2008 St. Mary's City, MD Edward N. Brinsfield, Jr M00052 22955 Hollywood Road, Leonardtown, MD Brinsfield Funeral Home, P.A. 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subarachnoid hemorrhage 6 days **Physician** /Medical Due to (or as a consequence of): Examiner Hepzto Renzl Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Cholangio CARCINOM death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 4 No 1 🗆 Yes 1∐ Yes 2 - NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 07

Scott Tidball, M.D. 2050 Wildewood Shopping Center, Hollywood, MD

32. Registrar's Signatur

1. April

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 12:30 PM 2008 Frank Lester Bailey May 11 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's California 45159 Woodside Way Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Months Days Hours 1 X M 2 □ F New York 48 02/03/1960 Director 124-58-2909 Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | St. Mary's California 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20619 United States 45159 Woodside Way Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 XNever Married 2 Married White 1 ☐ Yes 2 🛣 No 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government Contractor Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Mechanic 12 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paulette Marlyn Davis Donald James Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 45 Norfolk Street, Apt. #B Troy, New York 12180 Robin Lee Kratky / Sister permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Saratoga National 05/20/2008 | Schuylerville, NY. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield Jr 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician Physician/Medical attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 8 9 Unknown signed by onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 Physician: 25. Was case referred examiner? 26. Place of Death (Check onl e Be Other: 4 Nursing Home 2 No Hospital: 5 Residence 6 □Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 1 🔲 Inpatient Certification: To this 27. Man of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t Hospital or Attending Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) Boulevard of death (Item 23 California, MD. 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 3 2008

Division or Vital Records, P.O. Box 68760,

		1. Decedent's Name (First, Middle, Last	")				2.	Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Albe	rt Francis	Bagley,	Jr.		A	pril 30	,	0445 <sup>M</sup>
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location	ol Death		4c. County of Dea	ith
		Harford Memoria	al Hospital			Havre de				rford
Funeral Director		5. Social Security Number 6. Se 216-14-7442	7. Age (/. X M 2□F 8	n yrs. last birthday) 2 Yrs.	If Under Months		Min. N	Date of Birth (Month, Day, Ye NOV • 26,	9. Bir 1925	thplace (State or Foreign ountry) Maryland
		Usual Residence of Decedent	14/	Oc. City, Town or Lo						10d. Inside City Limits
r 28a-f ehow rotified at	ō	10a. State 10b. County Maryland Harfo		oc. City, Towit of Et		avre de (	Grace			1 ☐ Yes 2 ☑ No
288	Director	10e. Street and Number			10f. Zip	Code		10g.	Citizen of What C	ountry?
3a or		104 Lapidum Road				21078			U.S.	A.
1	Funerai	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Dece	dent of Hispanic O city Cuban, Mexica	rigin? (Specif	y Yes or No-	14. Race - Am	
au line	þ	1 ☐ Never Married 2 Й Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	1943 <b>-</b> 46 1950 <b>-</b> 54	1 ☐ Yes			an, etc.)	Black, Whi	White
les l	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usu	al Occupation ork done during mo	at of working	16t	. Kind of Business	/Industry
Med	pie	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT u	se retired)	st or working			
1	ПO	Eleven Years	,		\$	Salesman		P	utomobil	e Business
event,	Be	17. Father's Name (First, Middle, Last)				18. Moth	ier's Name (F	First, Middle, Mai	den Sumame)	
t c	70	Albert Fra	ncis Bagle	y, Sr.				Myrt	le Frye	
reumatic event, I		19a. Informant's Name/Relationship (7		19b. Maili	ing Address	s (Street and Numb	per or Rural P	Route Number, Ci	ity or Town, State,	Zip Code)
7.7.		Helen C. Wood-Bagl			_					and 21078
f Item 27 r other tre		20a. Method of Disposition 1	1	<ol> <li>Place of Dispersion</li> <li>Cemetary, cre</li> </ol>	osition (Na matory or t	me of other place)	Dat	9 200	. Location - City o	r Town, State
# <u>7</u>		4 Donation 5 Other (Specify		Harford Me	emorial	. Gardens	05/03	/08 Ab	erdeen,	Maryland
Importent: If it eny injury or o		21. Signiture of Funeral Service Licens	715× m	<_ I	ee A.	nd Address of Faci Patters ville, Ma	on & S		al Home,	P.A.
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	e death. Do not en	ter the mod	de of dying, such a	s cardiac or r	espiratory arrest,	-0700	Approximate Interval Between
eieiee		Immediate Cause (Final			ailur					Onset and Death
sician edical		disease or condition resulting in death)	a. Respira		aiui					
miner		1	. Respivator		c's .					IWEEK
	ē	Saguantiany fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due o (or as a c							
ansıı	Examin	Cause (Disease or injury that initiated events	Chronic	Obstruct	ive f	ulmona	de	zease		15 421.
rial-tr		resulting in death) Last	Due to (or as a c	consequence of):			-			
sician and e burial-transit	cai		d							
g phy as the	ed					-			-	
attending phys I for use as the	Completed by Physician/Medi	23b. was decedent pregnant	23c. If yes, outcome of 1□Live birth 2 [		□Ectopic p	reanancy			23d. Date of de	
a atte	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tim		Other (s				Month	Day Year
detached	hys	9 ☐ Unknown	9□ Unknown				-0.5		1	
d be det	<u>y</u>	Part II. Other significant conditions of				cause given in Part	I.	23e. Did tobac	co use contribute	to the cause of death?
n sig	g	Hypertension, t	typercholes	terole mia	١ ٠			1 X Yes	2 □ No 3 □ F	Probably 4 Unknow
nas been s ja 2 should	Set	Prostate Concer						24a. Was an	24b. Were a	autopsy findings availab completion of cause of
aga 2	Ë							autopsy performed	d? death?	100
or. p	Ü	25. Was case referred to medical				26 Pla	se of Death //	1 ☐ Yes 2 ☐ Check only one	(NO TELE	5 2/4/10
is certificete hi director, paga	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 KER/Outpatie	ent 3 D	1			e 6 ∐Other (Sp	ecify)
		27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury at Work?		d. Describe how		odiny)
After the	ţ	1 Natural 5 ☐ Pending investigation	(Month, Day Y	(ear) Injury	м	Work? 1 ☐ Yes 2 [	∃No			
Director: In by the	Certification:	3 Suicide 6 Could not be determined		- At home, larm, si (Specify)	treet, factor	y, office	28	1. Location (Stree City or Town, S		Rural Route Number,
	0	29a. Certifier 1 Certifying Ph	ysicien: To the best of rainer: On the basis of each	xamination and/or in	th occurred	at the time, date a	and place, an	d due to the caus I at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
24 hours af Funeral D itely filled in	<u>S</u>		and mariner states	· · · · · · · · · · · · · · · · · · ·		. Listana sumba		294	. Date signed (Moi	oth Day Year)
the Funeral D mpletely filled in	Medica	29b Signature and title of certifier			29	c. License number				
within 24 hours at To the Funeral D completely filled in	Medical	29b. Signature and title of certifier	<b>/</b>							
within 24 hours after de To the Funeral Direct completely filled in by th	Medica	29b. Signature and title of certifier  30. Name and address of person who			2	00184				1-2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** 2008 26, 14:45 PM Elsie R. Bostwick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Nursing and Kehabilitation Center E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 👿 F 222-03-3353 89 Director August 7,1918 | Maryland Usual Residence of Decedent 10a, State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 East Cecil Avenue 21901 United States 23a death items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after or ealth and Mental Hygiene. n 27 is marked other than "natural", or iten 1 ☐Yes 2 → No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert McKenney Annie Lynch 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Linda M. Bostwick / Daughter P.O. Box 46, North East, Maryland Pages 1 ment of H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April on 5 Other (Specify) 3 □ Removal from 4 ☐ Donation 29, 2008 Mayerdale Crematory Newark, Delaware 21. Signatur 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Densero disease or condition resulting in death) STAGE -10 unknown /Medical Due to for as a consequence of) Examiner AFB Sequentially list conditions, if any second conditions, if any second cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physiclan: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an certificate 211No 1 ☐Yes ₹☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur investigat n 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could n ≠ be determi ed 3 Suicide Be. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar 29a. Certifier

one) 29b. Signature and title

(Check only

30. Name and address of

31. Date filed (Mor

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1 2008

SZOVE

on who completed cause of death (Item 23a) (Type, Print)

817 Consensus

Medical

Cer ftying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

GR

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

New CASTLE DE 1972

29c. License number

D

			1 - For State Registrar	State of Maryla	-	rtment of H			giene Reg. No. 2	008		5
	Physicia		1. Decedent's Name (First, Middle, Last)	E.	BENTZ			2. Date of Dea Month MAY	ath	200 <sup>Y</sup> g <sup>ar</sup>	3. Time of Death 3:25 P M	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Walkers		ath	4c. Co	unty of Death	1	
	Funeral Director		5. Social Security Number 6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h /. Year)	9. Birth	place (State or Foreign intry) y Land	
	ryland how at		Usual Residence of Decedent  10a. State  10b. County	10c. C	City, Town or Loc	cation					10d. Inside City Limits	-
	ith the Ma or 28a-f s e notiflec	Director	Maryland Frederick		lkersvil	.1e 10f. Zip Code			-	of What Cou	1 □Yes 💥 No	
	r death witems 23a	Funeral I	10220 Dublin I	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	21793 spanic Origin? ( n, Mexican, Pue	Specify Yes or No-	USA	Race - Amer Black, White		_
0000	hours afte ural", or it	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2  No If Yes, Give Year or Dates:	1	☐ Yes 2 🔀 No	Specify:		Sp	ecify:	White	
-617	be fled within 72 hours after death with the Maryland Hygiene. All Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	- (Give	ent's Usual Occupa kind of work done d DO NOT use retired, Manager	ation Juring most of w )		Concr	of Business/I	ndustry	
מוות ע	d be filed ental Hygi ced other c event, II	Be	17. Father's Name ( <i>First, Middle, Last</i> )  James Brooke I	 Bentz	orrice	. Hallager		ame (First, Middle, ce Virgin	Maiden Su	rname)		
Masy	id 2 should th and Me 27 is mark traumation	٦	19a. Informant's Name/Relationship (Typ Mary L. Bentz – Wif	,		g Address (Street a	and Number or F	Rural Route Numbe	er, City or To	own, State, Z	,	
ווסומ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural!" or items 23a or 28a-f show any Injury or other traumatic event, the Medica Examiner must be notified at once.		20a. Method of Disposition 1			sition (Name of natory or other place		Date 9-2008		ion - City or T	Town, State Maryland	
Dall	permit. Pages 1 Department of I- Important: If Ite any Injury or ot once.		21. Signature of Funeral Service License	ee 1	22	Name and Addres	s of Facility	Stauffer	Funer	al Hom	e	2
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final	cations that caused the dea e cause on each line.	ath. Do not ente	er the mode of dying	g, such as cardi	ac or respiratory ar		it, nar	Approximate Interval Between Onset and Death	_
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a conse		my c	ance	-1			& years	-
-	cuted a	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conte	equence of):							
,00,0	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a conse	equence of):							
	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as to	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy			23d	. Date of deli Month	very Day Year	
, L (CD	signed by	by Phy	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	derlying cause give	en in Part I.	23e. Did to		11	the cause of death?	
	The law require has been age 2 should	Completed						24a. Was autop	an 2	24b. Were au prior to death?	topsy findings available ompletion of cause of	
VII	sician: The law certificate has b irector, page 2 s	o Be C	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2[	TER/Outnotion	Othe	7F.	1  Yes		1 ☐ Yes	2 No	-
5	Attending Physician: The sr death. rector. After this certificate he by the funeral director, page		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Li Nursing	Home 5 N Resid			ify)	-
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; p	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre city)	eet, factory, office		28f. Location (S City or Tow	Street and N vn, State)	lumber or Ru	ral Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dis completely filled in	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examination	ician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	occurred at the tin restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) an date and pl	d manner as ace, and due	stated. to the cause(s)	
)	Withi Vithi Com	M	29b. Signature and title of certifier	Land		29c. License	number + SISC	-1	29d. Date s	igned (Month	Day, Year)	
-	ptl		30. Name and address of person who co Elhamy ESKan	,	50   V	V 1th	Street	Freder	ick	, MD	21701	
F	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrat's Sign	nature #	Soule						-

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 3 Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day **Physician** 10:09 AM Mary Elizabeth Baker May 6, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Haure de Gruce

Hi Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Sept. 26, 1 Harkord Havre de Grace Harford Memorial Hospital 9. Birthplace (State or Foreign Country) 1925 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 217-22-3093 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State r then "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number U.S.A. 21001 700 W. Bel Air Ave Apt. 419 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 Is marked other then "neturel", or ite 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 20 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bowling Alley Desk Clerk Secretarial 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Leonard Singleton Elizabeth Margaret Kloid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau 1400 R Joppa Forest Rd. Joppa, MD 21085 Virginia Corona (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Holy Trinity Episcopal 5/10/2008 Churchville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulleral Service Licens 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) HYPER LIPIDEMIA **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner use as the burial-transit attending physicien and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 3 Probably 4 □Unknown 1 Yes 2 HO Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 1 NO Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 TYes \_2**□**₩6 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funerel D completely tilled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c License number 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 805 S. UNION AVE HD6 MD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2008 Registrar

Elizabeth

ichael Boone, Il	State of Maryland / Department of Health and  1- For State Certificate of Death  Registrar	Mental Hygiene Reg. No. 2008 1656						
Physician/ ledical Examine	1. Decedent's Name (First, Middle,Last) Michael Edward Boone, II	2. Date of Death Month Day May 9, 2008  3. Time of Death 0246 hrs						
L1.	Location of Death  4c. County of Death  Carroll							
Funeral Director	5. Social Security Number 216-02-3794 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Eoreign						
ow any	Usual Residence of Decedent  10a. State	10d. Inside City Limits 1 X Yes 2 No						
th the Maryland 23a or 28a-f sho notified at once	MD Carroll Finksburg    MD   Carroll   Finksburg							
or items	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 14. Yes 2 No 15. Was Decedent of Hisport In Yes, specify Cuban, 16. Yes, 2 No. 16. Yes, 2 No.	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  White						
5-0036 ed within 72 hours aft tygiene. the Medical Examble Completed by	15 December 15 Education (Creation of Section 2) 15 December 15 De	U.S. Army						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Michael Edward Boone, Sr.	18.Mother's Name (First, Middle, Maiden Surname)  Teresa Lynn Cordle  st and Number or Rural Route Number, City or Town, State, Zip Code)						
두 모 늘 모 했	Shannon Marie Boone/wife  20a. Method of Disposition  Burial 2X Cremation 3 Removal from State  Smithsburg Cremator	e Blvd. #18 Finksburg MD 21048 metery, Date 20c. Location - City or Town, State						
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  MO1414  J. L. Davis	of Facility  12525 Bradbury Ave.  Funeral Home Smithsburg, Md. 21783						
Physician /Medical  xaminer	23a Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Detween Onset and						
<u>.</u>	Sequentially list conditions.							
uted td ransit Fxaminer								
60, ate be executed hysician and e burial - transit	W UNPENDED #23a,27,28a-f, perME,g879 5/27/08	TT' 23d. Date of delivery						
by the attending physician or the death certificate by the attending physiched for use as the behave in a physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregnancy Month Day Year						
s, P.O. Baires that the de risigned by the detached f		1 Yes 2 No 3 Probably 4 Unknown						
24a. Was an autopsy performed?  1 Yes 2 No 1  25. Was case referred to medical examiner?								
of Vital ing Physician: After this certi uneral director	25. Was case referred to medical examiner?  1  Yes 2 No  28. Pate of Injury 28b. Time of Injury 28c. I	e of Death (Check only one)  Other; Nursing Home 5 Residence 6 Other:  Jry at Work?  28d. Describe how injury occurred						
ivision or Attend after death. Director: J in by the f	Yes 2 X No unk  building, etc.  28f. Location (Street and Number or Rural Route Number, City 25f. Location (Street and Number or Rural Route Number, City 25f. Baltimore Blvd. Finksburg, MD							
To the Hospital within 24 hours To the Funeral completely filler		n, death occurred at the time, date and place, and due to the cause(s)						
	high. mo o.c.	se number 29d. Date signed (Month, Day, Year)  .M.E. May 9, 2008						
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201						
Stat	31. Date filed (Month, Gay Kear) 2 1 20 32. Registrar's Signature							

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Mary State Registrar		rtment of Heal		Reg	ene g. No. 2 (	108	16561
ř	Physicia	an	Decedent's Name (First, Middle, Last)  AGNES ELEANOR CHISLEY				2. Date of Death Month MAY	3,	2008	3. Time of Death 4:00 PM
*	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca	tion of Death		4c. County	of Death	
- 1			PINEVIEW FUTURE CARE NURSING 5. Social Security Number 6. Sex 7. Age (Ir	HOME  yrs. last birthday)	CLINTON  If Under 1 Year   If U	nder 24 Hrs.	8. Date of Birth		CE GE	ORGES  ace (State or Foreign
	Funeral Director		404 005	4 Yrs.		urs Min.	8. Date of Birth (Month, Day, APRIL 8,	1924	MARY	
	and t		Usual Residence of Decedent         10a. State         10b. County         10	c. City, Town or Loc	cation				10	d. Inside City Limits
	e Mary a-f sho tifled a	ctor	MARYLAND PRINCE GEORGES	TEMPLE H	IILLS					1X Yes 2□No
	with the	Director	10e. Street and Number 3420 RICKEY AVENUE, APT. #12	3	10f. Zip Code 20748			g. Citizen of t NITED		
	death	Funeral	12 Was Docadent Eye		Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Spe		14. Rac	ce - America	n Indian,
9	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Fu	11. Marital Status  1		v	ecify:		Specif		
2-003e	72 hou natura dical E		15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during	most of worki		6b. Kind of B	usiness/Ind	ustry
LZ.LZ	filed within Hygiene. Ither than "ent, the Mer	duc	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired)  LD CARE PROV	/IDER		CHILD	CARE	
naz	be filed withintal Hygiene.  d other than event, the M	Be Completed	17. Father's Name (First, Middle, Last)	<u> </u>			(First, Middle, M		ne)	
Maryland		2	GOLDIE CHISLEY  19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and N	-			, State, Zip	Code) 20748
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		AGNES E. CHISLEY / SELF	3420	RICKEY AVEN	NUE, AP	T.#123,	TEMPLE	HILL	S, MARYLAND
altimore,	0 0 <del>-</del> -		TIALBURAL 2 LICTEMATION 31 IBEMOVALITOR State 1		osition (Name of matory or other place)			Oc. Location	•	
######################################	permit. Pag Department Important: I any Injury o		4 □ Donation 5 □ Other (Specify)  21. Signature/of Fun and Security Licensee	22	CHURCH CEMETER Name and Address of HORNTON FUN	Facility				
ñ	Der Imp		LYDIA C. THORNION JOHNSON MOOSE		439 LIVINGS	I'ON ROA			, MAR	
	Physician /Medical	8 9	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	v of	Braint	with	meta	st asi	d	Approximate Interval Between Onset and Death
	Examiner		Due to (or as a co	onsequence of):						
ě.	per	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):						
o,	ficate be executed physician and sthe burial-transit	Examiner	that initiated events c	onsequence of):						
58760,	cate be ohysicia the bu	edical	d							
P.O. Box 6	ath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive	ery Day Year
	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	ınderlying cause given in	Part I.	23e. Did tob		ntribute to th 3	ne cause of death?
Records,	w requ	Completed					24a. Was ar		. Were auto	psy findings available
Re	The lav	Somp					autops perform 1 Yes 2	ned? ! <b>X</b> No	death?	inpletion of cause of 2□ No
Division or Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?  1. TVs. 2010 No. Hospital: 1. Turnetiest	2 ☐ ER/Outpatie	Othor		th <i>Check onl on</i>		thor (Casaif	iv)
J Or	ig Physter this neral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o		LANUISING HO	28d. Describe ho			<i>y)</i>
Sior	Attending r death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury		M 1 ☐ Yes	2 □ No	28f. Location (St	reet and Num	ber or Rura	al Route Number.
<u>&gt;</u>	al or Assault or Assault Direct	Sertiff	4 Homicide determined building, etc. (		root, laotory, omeo		City or Town	, State)		,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of representation of the basis of evaluation and manner states	kamination and/or ir	th occurred at the time, on nvestigation, in my opinion	date and place, on, death occu	, and due to the carred at the time, d	ause(s) and n ate and place	nanner as s e, and due t	tated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	<del>-</del>	29c. License nui			9d. Date sign		
•			30. Name and address of person who completed cause of deat	th (Item 23a) (Type				MAY 6,	, 2008	5
	133		BAHRAM PISHDAD, M.D. 1328	SOUTHERN	AVENUE, S.	E., SUI	TE #310,	WASH]	NGTON	I, D.C. 2003
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's MAY 0 7 2008	Signature	book					

$\mathbf{\tilde{E}}$
Records, I
or Vital
Division

			For	ase Type or State o		d / Depa	artment of H	lealth	and Me	-		-	е.	
			State     Registrar  1. Decedent's Name (First, Midd.)	lo Lact)		Cei	rtificate of	Death		Date of De	Reg. No.	200	3.	Time of Death
	Physicia	an	Maureen Coffe							Month	Day		ear	2:35 P M
	/Medic	A 190	4a. Facility Name (If not institution		mher)		4b. City, Town, o	r Location		lay 19		County of E		2133 1
	Examin	er	Bowie Emergence		,,,,,		Bowie				Pr	ince	Georg	e's
1	Funeral		Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year			B. Date of Bi (Month, Di	rth		Birthplace	(State or Foreign
Ь	Director		037-22-2434	1□M 2XTF	75	Yrs.	Months Days	Hours	Min. Ji	ıly 20	, 19	32 R	hode	Island
	pur »		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	y, Town or Lo	cation						10d. I	Inside City Limits
	sho sho	ō		ce George'									1	1 XYes 2 □ No
	the N	Directo	Maryland Prince  10e. Street and Number	de George	S DOW	TE	10f. Zip Code				10g. Cit	izen of Wha	t Country?	
	with yard		15007 Nutcrack	or Place			20716				USA			
	heath ms 2; mus	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	lispanic O	rigin? (Speci	fy Yes or N		14. Race - /		ndian,
ယ	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examiner must be notified at	Ē	1 ☐ Never Married 2 ☐ Mar	rried Armed Formed 1 ☐ Yes If Yes, Gi	2 <b>X</b> No		ir Yes, specily Cub 1 □ Yes 2 No	an, Mexica Specify		icari, etc.)			White, etc.	
8	rai", c	l by	3 X Widowed 4 ☐ Divorced	d Year or D	ve ates:		TE TES ZEINO	Эрвспу	,. 			Specify:	White	
5-0	72 h 'natu dical	etec	15. Deceder (Specify only higher	nt's Education est grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during mo	st of working	7	16b. K	ind of Busin	ess/Industr	ry
21215-0036	within iene. than "ithe Mec	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	Home		a)			Over	Home		
	e filed v al Hygie I other t vent, th		12 17. Father's Name ( <i>First, Middle</i>	. Last)		поше	riakei	18. Moth	her's Name (	First, Middle	<del></del>			
and	d be i	Be c	Walter Charbon					Marv	Ware					
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	은	19a. Informant's Name/Relation			19b. Maili	ng Address (Street			Route Numi	ber, City	or Town, Sta	ate, Zip Coo	de)
Ma	nd 2 s ulth ar 27 is r trau		Susan Taylor/	Daughter		50 Ta	ljen Ave	nue M	lartin	sburg,	WV	25403		
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. P	Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Da	te	20c. L	ocation - Cit	y or Town,	State
Baltimore,	permit. Pages Department of I Important: if its any injury or o		1 ABurial 2 □ Cremation 4 □ Donation 5 □ Other (		State M	arylan Cemet	matory or other pla id Vetera: erv	nś	5/5/20	800	Che	ltenh	am, M	D
ati	permit. Departmine importa any inju		21. Signature of Funeral Service	e Licensee		2	2. Name and Addre	ess of Faci	ility Rob	ert E.	Eva	ıns Fu	neral	Home
Ö	Per E		23a. Part1. Enter the disease, of	Dunt			6000 Ann					D 207	15	
60,	Physician /Medical Examiner bulkisician and street bunari-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequence of the cons	uence of):	ic (ar	diov	145 66	dav	Itec	ut 3	Disea	ese
P.O. Box 68760	death certif e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live 4 ☐ Preg 9 ☐ Unkr		al death 3[ leath 5[	⊒Ectopic pregnanc ⊒ Other (specify) _					23d. Date of Month	n Day	
Ś	as the	þ	Part II. Other significant condit	tions contributing to o	leath but not res	ulting in the u	ınderlying cause gi	ven in Par	t I.					ause of death? y 4
Record	w require been signatures	lete								24a. Wa		24b. We	re autopsy	findings available
Re	0 - 0	Completed			-					aut per 1□ Yes	opsy formed? 2 N	dea	ath?	etion of cause of ∃No
Vital	siclan: The certificate I rector, pag	Be C	25. Was case referred to medic	al				26. Pla	ce of Death			V   100		
r V	d: is: ₹	To E	examiner? 1,□ Yes 2□ No	Hospital: 1 □	Inpatient 2	ER/Outpatie	nt 3□ DOA Ot	her: 4 🗆 l	Nursing Hom	e 5 ☐ Re	sidence	6 □Other	(Specify)	
n or	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date	e of Injury nth, Day Year)	28b. Time o Injury	Wo	iry at ork?	2	8d. Describe	how inju	ury occurred		
Division	spital or Attendi tours after death. neral Director: A	Certification:	2 Accident inves 3 Suicide 6 Could	tigation d not be 28e. Plac	e of injury - At he ding, etc. (Specil	ome, farm, st	M 1 creet, factory, office	]Yes 2[			(Street a		or Rural Re	oute Number,
Ω	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Cer	29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medica	ring <b>Physician</b> : To the al <b>Examiner:</b> On the and ma	e best of my kno basis of examina nner stated.	owledge, dea ation and/or i	th occurred at the to	ime, date opinion, d	and place, a leath occurre	nd due to the	e cause( e, date ar	s) and manr nd place, an	ner as state d due to the	ed. e cause(s)
	To the Hos within 24 hc To the Fun completely	Me	29b. Signature and title of certif	ier	- 1.		29c. Licen	se numbe	r		29d. D	ate signed (	Month, Day	v, Year)
	- PN	N	Anhah	J/3/8	Sto D	0	He	205-5	-97	7	M	12 7	1,20	308
(	4 CAX		30. Name and address of person	on who completed cau	use of death (Iter	n 23a) (Type	, Print)		97	/	1	1.	/	2
_	THE		Salvador Si	KYSTER		Hosp	ital I	mine	20	ang	5	Mo	ing (	and
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea	6 2008	egistrar's Signa	ature A	meter .				01			

DHMH 17 Rev 1/2001

10d. Inside City Limits

Day

EFENSE HIGHWAY ANNAPOLISMO LIVE!

Year

1 ☐ Yes 2√√No

Registrar

State

ICH

31. Date filed (Month, Day, Year)

MAY 0 6

32 Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Please Type or Print in Bla	ck indelible ink.	Ensure All C	opies Are Legi
State of Maryland	Department of H	ealth and Men	tal Hygiene

		,	For State Registrar		State of M	laryland		artmen rtificate			and M	ental	Hygie <sub>Reg</sub>	F15 F15	ınα	16	561
	Physici		1. Decedent's Name (Fire William H.									2. Date of Month	of Death		008	3. Time o	
The same of the sa	/Medio Examin		4. F. W. M. W. Charles and A. Charle										4c. County Anne	of Death	lel		
	Funeral Director		5. Social Security Number 212–16–432 Usual Residence of Dece	27	Sex 7. A 1 <b>X</b> M 2 □ F	ge (In yrs. la 87	a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of (Mont) June		ear) 1920		lace (State stry) yland	o <i>r Foreig</i> n
	e Maryland ta-f show	ctor	10a. State 10b.	County	rundel		, Town or Lo				-				1	0d. Inside C	City Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 570 Beller	cive D	rive Apt.	430		10f. Zip	Code 21409	)			10g	. Citizen of U	What Cour	itry?	
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventinal must be redified at	by	11. Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ [		12. Was Decedent Armed Forces' 1⊈ Yes 2 ☐ If Yes, Give Year or Dates:	? No <b>194</b> :	3-	Was Deced If Yes, spec 1 □Yes 2				cify Yes o	or No- .)		ce - Americ ck, White, y: $ abla$		
21215-0036	filed within 72 h Hygiene. other than "natu ant, Ing Medical	Completed	15. I (Specify on Elementary/Secondary 12		ducation ade completed) College (1-4or	5+)	(Give	dent's Usua kind of wor DO NOT us Self	k done d e retired,	uring mosi )		g	16	b. Kind of B	usiness/Ind		
Maryland	should be filed withi and Mental Hygiene. s marked other that umatic event, Ing.	To Be (	17. Father's Name (First, Henry Chri		t) 						er's Name largar			iden Surnar E <b>er</b>	ne)		
, Mar	and 2 sho fealth and m 27 is m		19a. Informant's Name/F William H.	. Chri			2000	Grif	fis	Ave.	Bal	Ltimo	re,	MD 21	230		
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra		4 ☐ Donation 5 ☐	emation 3 E Other <i>(Speci</i>		;	ace of Dispo emetery, crer etro Ci	remato	ory		May 2 2008	ete O	- 1	c. Location Balti	•		
Bal	permi Depar Impor any ir		21. Signature of Fune al  23a, Part1. Enter the dis	- 56-	216		Ba 49	Name and Price of Section 1975 Gov	20 & 7. Ri	Sons Ltchi	e P.F.			na Pa na Pa	rk Furk, M	neral D 211	•
	Physician bhysician and physician and the buffar-transit in the buffar-transit	l Examiner	shock, or heart fallt Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ure. List only	b. Due to (or as	ine. RICL s a consequ	lace of):	A	my	thon	1100					Interval Be Onset and	tween Death
, P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown  Part 1i. Other significant	hs?	23c. If yes, outcom  1	2 ☐ Fetal at time of de	death 3E eath 5E	Ectopic por Other (sp	ecify)			23e.	— Did toba		ate of deliver	Day	Year death?
of Vital Records,	e law requires has been sign e 2 should be	Completed by	fc	ell	re to	150	ue					24a.	1 ☐ Yes Was an autopsy		Were auto	psy findings	available
/ital R	Physician: The r this certificate har ral director, page	Ве Соп	25. Was case referred to examiner?	medical						-	of Death	1 🗆 Y	es 🛂	do	death?	2 □ No	
	<b>ling Phys</b> ). After this funeral dir	Certification: To	2 Accident	Pending investigation	28a. Date of Inj (Month, D	ury	ER/Outpatier 28b. Time of Injury		8c. Injury Work	#∐ NL	2	_		ce 6 □ Otl injury occur		y)	
Division			4 ☐ Homicide	Could not be determined	building, e	etc." (Specify	·)					City o	r Toʻwn,				mber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		Medical Exa	hysician: To the bes miner: On the basis and manner s	of examinat		vestigation		oinion, dea			time, date		and due to	the cause	(s)
	V-7-71		) ICH		accompleted online of	death (Itam	220) /Time		_	5702	8				02-		
	Sta Registr		30. Name and address of Adj tya C 31. Date filed (Month, Da	hopro	m.D. 6	OO k	21dge	ely 2	Aver	rue.	Anr	)cype	15	mD	) 2	1401	

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Maryland Hygiene (1998)  The State of Seath State of Maryland / Department of Health and Maryland Hygiene (1998)  The State of Seath State of				Please Type or Print in Black Ind		•	_
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William Patrick Curley  William Patrick Curley  William Christop  William Patrick Curley  William Christop  William Chri					incate of Death		
As   Feether   March   Country of Double   C		Physicia	an				au V
The state of the s			100		4h City Town or Location of Death	May	
Control processor   Cont		Examin	er		La Plata		Charles
18.3 = 20 - 9.84 2   XZo		Funoval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	9. Birthplace (State or Foreign
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The property of the property	121	vithin han '	ם	Elementary/Secondary (0-12) College (1-4or 5+)	,	ant II	C Air Force
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200. Location - City or Town, State    Double	ar.	shou nd M mar	-				
Compared to the control of the con		and 2 alth a 27 is		William J. Curley/Son 6008	Black Bear Ct.		
Physician   Phys	ore			cemetery crem	atom or other place)	Date 20c.	Location - City or Town, State
Physician   Phys	Ĕ	Pag ment ant: I		4□Donation 5□Other (Specify)   Metropol	1		
Physician Medical Examination and Cause Final Services of Condition (Caste only one case on each line)  238. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Intrivial Between Chest and Death (Caste Final disease) or condition (Caste only one case on each line)  248. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Intrivial Between Chest and Death (Caste Chest on	Salt	ermit. repart report ny Inj nce.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Ra	aymond Fu	nl.Service, P.A.
Physician (Medical Examiner    Medical Examiner   Physician (Medical Examiner)   Physician (M		⊕ CD = # 64					
Security				shock, or heart failure. List only one cause on each line.	ALINE MERCHANIST	or respiratory arrest,	Interval Between
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FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	oʻ	⊕ ⊆ œ		resulting in death) Last Due to (or as a consequence of): V			
FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	928	ate be hysici the bu	lical	d			
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9 Unknown 9 Unkn	Bo	attenc for us	ian/	in the past 12 months?			,
The state of the s		the de	ysic	1 Yes 2 Li No	Other (specify)		
24a. Was an autopsy performed?  1   Yes 2  No  24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2  No  25. Was case referred to medical examiner?  1   Yes 2  No  26. Place of Death (Check only one)  27. Manyer of Death  1   Natural conditions available prior to completion of cause of death?  28. Place of Death (Check only one)  28. Place of Injury At home, farm, street, factory, office  28. Place of Death (Check only one)  28. Place of Injury At home, farm, street, factory, office  28. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omous MD Cenna Medical Context 7-C Post Office Rd. Wellarf Md 2000  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	that led by detail		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6   Other (Specify)  Other: 4   Nursing	rds	quires n sigr uld be	q p			1 X Yes	2 No 3 Probably 4 Unknown
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6   Other (Specify)  Other: 4   Nursing	ပ္သ	aw re	olete				24b. Were autopsy findings available
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? 1   Yes 2   No 28d. Describe how injury occurred  1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? 1   Yes 2   No 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only of Death) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and difference of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters  7-C Post Office Rd. Weidorf Ma 2000  State  31. Date filed (Month, Day, Year)  28c. Injury at Work? 1   Yes 2   No 28d. Describe how injury occurred 28d. Describe how injury occu	Ä	The I	ШО			performed?	? death?
27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? 1   Yes 2   No 28d. Describe how injury occurred  1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury M 28b. Time of Injury M 28c. Injury at Work? 1   Yes 2   No 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only of Death) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and difference of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters  7-C Post Office Rd. Weidorf Ma 2000  State  31. Date filed (Month, Day, Year)  28c. Injury at Work? 1   Yes 2   No 28d. Describe how injury occurred 28d. Describe how injury occu	ita	slan: ertifica ctor, p	0				
State   Stat	7	hysic this co	0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			
State    State	n C	ng fte	iuo	1 Natural 5 Pending (Month, Day Year) Injury	Work?	28d. Describe how in	njury occurred
29a. Certifier (Check only one) 29b. Signature and ditle of certifier (Signature and ditle of certifier (Check only one) 29b. Signature and difference of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters 7-C Post Office Rd. Wildorf Md 202  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one) 29b. Signature and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters 7-C Post Office Rd. Wildorf Md 2020  31. Date filed (Month, Day, Year)  32c. Registrar's Signature	Sic	death death stor	cati	3 Suicide 6 Could not be 280 Place of injury - At home farm stre		28f Location (Street	and Number or Rural Route Number.
29a. Certifier (Check only one) 29b. Signature and ditle of certifier (Signature and ditle of certifier (Check only one) 29b. Signature and difference of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters 7-C Post Office Rd. Wildorf Md 202  31. Date filed (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only one) 29b. Signature and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Canters 7-C Post Office Rd. Wildorf Md 2020  31. Date filed (Month, Day, Year)  32c. Registrar's Signature	Dic	after of price of the by	ertif	4 ☐ Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , ,	City or Town, Sta	ate)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Center 7-C Post OFFICE Rd. Weldorf Nd 2000  State 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year)		spita nours neral y fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	e, and due to the cause	e(s) and manner as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Abbas A. Omais MD Cenna Medical Center 7-C Post OFFICE Rd. Weldorf Nd 2000  State 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year)		he Hc in 24 I he Fu pletel	edic				
State 31. Date filed (Month, Day, Year)   © Registrar's Signature		To t To t Com	Σ	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
State 31. Date filed (Month, Day, Year)   © Registrar's Signature				JIWS WIB	105	5	3/14/08
State 31. Date filed (Month, Day, Year)   © Registrar's Signature				30. Name and address of person who completed cause of death (Item 23a) (Type,	Contese 7-C C	SE DECICE A	End Ludge and Decor
Registrar MAY 2 1 2008		Str	ate	31. Date filed (Month, Day, Year) \$2. Registrar's Signature	Ma	J OFFICE I	- Mintered I and an one
	19.5			MAY 2 1 2008			



To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

`	0.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?
HTN: Paceura	Ker for 3° AVBlock: DM Type II:	1 ☐ Yes 22 No 3 ☐ Probably 4 ☐ Unknown
Arthritis: Me BPH TObstract	ningioma: GERD: HH: ACholATG 2	24b. Were autopsy findings available prior to completion of cause of death?  ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Che	eck only one)
examiner? 1 ☐ Yes 2月 No	Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. D	Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determined	, 28e, Place of injury - At nome, farm, street, factory, office 201. Li	ocation (Street and Number or Rural Route Number, ity or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, and diaminer: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	

29c. License number

D0050996

29d. Date signed (Month, Day, Year)

14/08

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 21

Neil Stoddard, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brown St. Chestertown, MD. 21620

DK

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 200 E 10 am Julian Llewellyn Cross 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 10748 Appletree Lane Williamsport Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Mary Land 8. Date of Birth (Month, Day, Year) June 17, 1935 5. Social Security Number 7. Age (In yrs. last birthday 1 XM 2 □ F 72 217-32-6303 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 10748 Appletree Lane 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1961 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: Specify. 3 Widowed 4 Divorced 1964 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis L. Cross Marv K. Huntzberry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10748 Appletree Lane Williamsport, Maryland 21795 Susan W. Cross - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Smithsburg Crematory May 12,2008 Smithsburg, Maryland 4 Donation 21. Signature of Funers OSNOPINE AFTER EFSITY Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. eart failure. Immedia Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or sere consequence of)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

and burial-tran attending physician for use as the buria been signed by the should be detached page 2 s

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or

Medical

State

Registrar

that initiated events resulting in death) Last	C
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   Yes   3   Probably   4   Unknown
	24a. Was an autopsy performed?  1□ Yes 2□ No 1□ Yes 2□ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1   Yes 2   No
3 Suicide 6 Could not to 4 Homicide determined	
	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 OPAL CT

29c. License number

29d. Date signed (Month, Day, Year)

9  $\Delta\Delta$ 

Year) 1 2 2008

29b. Signature and title of certifier



3H5+1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 5, 2008 Physician Crowley 8:30 A Michael Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 28, Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**x**x M 2□ F 89 1918 **Director** 129-05-4557 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 KNo Director Maryland Prince George's Suitland 5 2 2 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4669 Lacy Avenue 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XX yes 2 □ No 1944-If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Officer Navy Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Thomas Crowlev McGuire 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Watson Crowley / Wife 4669 Lacy Avenue Suitland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Vet. Cemetery 05/09/2008 Cheltenham, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical D f to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 2 Accident 5 ☐ Pending investigation 1 Tes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of per no completed cause of death (Item 23a) (Type, Print) MD 12070 Old Line Centre Louis V. Kaufman #207 Waldorf, Maryland 31. Date filed (Month, Day, Year)

State Registrar

MAY 0 8 2008



			For	partment of Health and I	Mental Hy	giene	
			Togrand	ertificate of Death		Reg. No.	8, 16569
r	Physicia	an	1. Decedent's Name (First, Middle, Last)	. —	2. Date of De	Day Year	
	/Medic	al	Jerome Kenneth Corr 4a. Facility Name (If not institution, give street and number)	igan  4b. City, Town, or Location of Death	May 4,	4c. County of De	4:03 P M
	Examin	er		Clinton			George's
1,3-	Funeral		Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ay) If Under 1 Year   If Under 24 Hrs.	8. Date of Bird	th QR	irthplace (State or Foreign
	Director		473–20–9221 <b>MX</b> № 2□F 82 Yrs	Months Days Hours Min.	Month, Da May 7,	1925	Minnesota
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. Cify, Town o	Location			10d. Inside City Limits
	aryla shov	<u> </u>					KX Yes 2 □ No
	the M 28a-f iotifie	Director	Maryland Prince George's Forest  10e. Street and Number	Heights  10f. Zip Code		10g. Citizen of What (	Country?
	with the r		5505 Woodland Drive	20745		USA	,
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No	14. Race - An	nerican Indian,
9	after (		MXXVever Married 2 Married XXX Yes 2 No 1943 →	1 ☐ Yes 2 ₩No Specify:	to Rican, etc.)	Black, Wh	White
03	ours a	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1940			, , ,	
5	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation five kind of work done during most of wor fe. DO NOT use retired)	rking	16b. Kind of Busines	s/Industry
121	within ene. than the Me	ш		lead Librarian		Oxon Hil	11 Library
d 2	e filed at Hygid other vent, th		17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle,	, Maiden Surname)	<u> </u>
lan	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be	John Corrigan	Helen	Willi	ams	
ary	2 should be and Menta is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print)	ailing Address (Street and Number or Ru	ural Route Numb	er, City or Town, State	, Zip Code)
Ž	and 2 salth a n 27 Is er trau			O Kingman Place N.W. Wa	ashington,	DC 20005	
ore	of He			sposition (Name of crematory or other place)	Date	20c. Location - City of	
ij	Pag ment tant: I		4□Donation 5□Other (Specify) Kalas (		8/2008	Edgewater,	-
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra	0 8	21. Signature of Funeral Service Licenses	22. Name and Address of Facility Ge 6160 Oxon Hill Road Ox			Home P.A. 0745
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician	î ji	Immediate Cause (Final disease or condition	ory Failure			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a con equence of)				
E	Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate	LIC CARCINOM	2		
	ted nsit	nine	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
,	execu and al-tra	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of)				
8760,	ate be executed only sicial and the burial-transit	dical I	d				
9	tificat ig phy as th	ledi					
Box	leath certific attending p I for use as	N/us	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of o	,
	ed for	Physician/Me	1 Yes 2 No	5 Other (specify)		Month	Day Year
P.0	that the de ed by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	o underlying gauge given in Dest I	220 Did 1	tobacco uso contributo	to the cause of death?
	requires that the death certific een signed by the attending p nould be detached for use as	by	Chronic Obstructive Pulmon		XXX		Probably 4 Unknown
Ö	w requires been signer should be	eted		THEY PISENCE			
or Vital Records,	e la has je 2	Completed	Diabetes Mellitus		24a. Was auto perfe	psy prior t	autopsy findings available o completion of cause of ?
a			25. Was case referred to medical	00.81 - /.8		2124 No 1 □ Y	
5		o Be	examiner?  1  Yes	Other	ath <i>(Check only o</i>	one) idence 6 □Other (S	pacifu)
10	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injury at	т — — — —	how injury occurred	
ion	Attending r death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	l or Atte after de: Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	lospital or Att t hours after de uneral Direct ely filled in by t	Cer	VV				
	- 2 - te	edical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, of the basis of examination and/and manner stated.	leath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the curred at the time	cause(s) and manner , date and place, and c	as stated. due to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)
	(20)		1 / Etille	D19889		05-05-2008	
2	20/1		30. Name an address of person who completed cause of death (Item 23a) (Ty Jaime F. Botello MD 1328 Southern Avenue	S.E. Washington, D.C.	20032		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 8 2008  MAY 0 8 2008				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 9:10 PM **Physician** 2008 ita Cumberland /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland Bostimore University of If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 236-18-7246 7. Age (In yrs. last birthday) 88 Yrs. 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F 4-15-1920 Weston. WV Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ns 23a or 28a-f shov must be notified at 1 □XYes 2 □ No MD Prince George's Laure1 Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20708 United States Items 23a 9010 Briarcroft Lane Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Examiner Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ites 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No altimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Telephone Operator Phone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veronica E. Mertz William D. Bateman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30080 Brokenarrow Lane Mechanicsville, MD 20659 Nick Graham ( Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 5/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Libensee 3401 Bladensburg Road Brentwood, MD 20722 110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain Lniun Physician Irannatic /Medical Due to (or as a consequence of): Examiner APPRUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical 33 attending | | for use as IF FEMALE yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 live birth Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Hupertension autopsy performed. Yes 2 No Diabetes certificate 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death Check onl one Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospina v. within 24 hours after death. To the Funeral Director: After this c ပ္ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 ☐ Natural 2 ☐ Accident found down 5 Pending Patient 16/08 2 **⊡**√No 4:30 PM 1 🗆 Yes investigation 281. Location (Street and Number or Flural Route Number, City or Town, State) 9010 Bn ar coff Lane #105 Lanel 6 ☐ Could not be 3 ☐ Suicide lace of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Home (apartment) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier,

(15) State

State 31. Date filed (Month, Day, Year)
Registrar MAY 0 8 2008

32. Registrar's Signature

30. Name and address of person who commeted cause of death (Item 23a) (Type, Print)

22 South Greene Street

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a, 25, per ME g883 9/17/08 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician  $P^{M}$ 2008 9:30 May 07 James Roscoe Curtis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Charlotte Hall Maryland Veterans Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours **Funeral** 578-40-0303 1 M 2 □ F 20,1925 Maryland 83 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 1 ☐ Yes 2 TNo Chaptico Directo Maryland | St. Mary's 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20621 United States 23590 Maddox Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1XXX es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housing Apartments Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Norman Curtis Emma Nelson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23590 Maddox Road, Chaptico Maryland 20621 Mary O. Curtis / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition NXBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Cemetery 05/14/2008 | Bushwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Road Leonardtown, Maryland 20650 M01206 Kyle S. Simons Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 26. Place of Death (Check only one) Be Hospital: Other: 1 ▼Yes <del>2 No</del> Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 2 ☐ ER/Outpatient 3 DOA ၉ After this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 TYes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director: 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ti son who completed cause of death (Item 23a) (Type, Print) 29449 Charlotte Hall Road, Charlotte Hall, Maryland 20622 Stephen Cafferty, M.D. 32. Registrar's Signatur 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 30, 2008 Mabel E. Porter Dobbins April 0340 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7, Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 E Director 577-30-3876 84 Jan. 3, 1924 Wash., DC Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☑ Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r Items 23a or 2 Iner must be n 3298 Ft. Lincoln Dr. 20018 Apt. 314 U.S.A. Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23. ury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify **Black** 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Renetta Coleman Moses Porter ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6421 Elliott Pl., Hyattsville, MD 20783 19a. Informant's Name/Relationship (Type. Print) Thomas S. Chase /Son Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 Donation 5 Dother (Specify) May 6, 2008 Brentwood, MD Ft. Lincoln Cem. 22. Name and Address of Facility Ft. Lincoln F. H. 21. Signature of Funeral Service Licensee a 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypoxemic respiratory failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Pulmonary fibrosis Due to (or as a consequence of) Box 68760. use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 sign be Pulmonary hypertension, hypertension, diabetes mellitis 1 Tes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No chronic renal insufficiency, leukocytosis 24a. Was an page 2 s autopsy performe 1∐ Yes 2K No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.0. Division or Vital Records. To the Hospital or Attending Physician: ours after death.

neral Director: Af within 24 hours a

To the Funeral I

completely filled

State Registrar

Natasha Lamming-Lee, 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

MD, 7610 Carroll AVe., 32. Registrar's Signature

hers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

#360

29d. Date signed (Month, Day, Year)

Takoma Park, MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14 2008 5:30 P.M Taiko Nemoto Dehart May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, ) 2/9/1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 10 15 80 432-90-4219 Director <u>Japan</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 K Yes 2 □ No Directo MD Harford Aberdeen 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21001 57 Dixon Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Japanese þ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 12 Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Dehart 950 Sunset Valley Dr. Sykesville, MD 21784 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 🏂 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 her (Specify) A. Ferris & Co. 5/22/08 West Chester, PA 21. Signature 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** CANCER, MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o 9 🔲 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOS PICE Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natura! iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DANIEUE DOBERMAN, MO

31. Date filed (M

Year)

DHMH 17 Rev 1/2001

2002

6565 N CHARLES ST, SWIE 209

2. Registrar's Signature

BALTIMORE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended#31,5-12-2008, 1- State 1gb, stmarysco. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Mav 10:45 **Physician** 2008 Richard Lee Dave /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25877 Jones Wharf Road St. Marv's Hollywood 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, March 31, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** District of Columbia 214-48-9333 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director St. Mary's Maryland Hollywood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 25877 Jones Wharf Road USA 20636 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Construction Manager U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Warren Dave Mary Elizabeth Ware ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Lee Daye / Wife 25877 Jones Wharf Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any Injury or c 1 ☐ Burial 2 【XCremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory May 13, 2008 | Alexandria, Virginia 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Light P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Inter the disease, or o' implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final **Physician** ) rain 115/07 disease or condition resulting in death) 5/7/08 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entail Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 X Natural 5 Pending Injury 2 🗆 No investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 10054263

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: To the Hospital

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

assan 31. Date filed (Month, Day, Year)

Name and address of person who

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Dr Mukhtar Hassan

25500 Pt. LOOKout Rd

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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been stoned by the attending physician and

	For State Registrar	Plea	State of M	laryland / D	epartme <i>Certifica</i>				giene Reg. No.		The state of the s
Physician /Medical	1. Decedent's Na Nichol		inic D'Adam	o				2. Date of De	ath Day	2008 <sup>ear</sup>	3. Time of Death 8:44 PM
Examiner		Newland	on, give street and number  S Street  6. Sex 7. A	ge (In yrs. last birt	thday) If Und	l <b>echan</b> er 1 Year	Location of Death icsville If Under 24 Hrs.	Doto of Bid	S	t. Mar	y's
Director	162–58 Usual Residence	of Decedent				s Days	Hours Min.	January	7 1,19	59 Pen	nsylvania
Ba-f shov	10a. State  Marylan		Mary's	10c. City, Town	anicsvi	.11e					10d. Inside City Limits 1 ☐ Yes 2 No
inter death with the man	10e. Street and Number 37403 Newlands Street 20659									n of What Co	
by	11. Marital Statu 1 □ Never M 3 □ Widowe	If Yes, Give	? ] No			ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Black, Whit		
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and Meni	19a. Informant's	Name/Relation	ph D Adamo ship (Type. Print)				and Number or R	orothy M	er, City or T	Town, State, .	Zip Code)
t of Health	20a. Method of I	Disposition	o / Wife 3 □Removal from State	20b. Place of cemeter	Disposition (f	ame of r other plac	S Street May	Date	20c. Loca	ation - City or	
Department Department mportant: Iny injury o	4 □ Donatio	n 5 □ Other ( Funeral Service	Specify)	Cemetery	22. Name Mat	and Addres	ss of Facility -Gardiner	2008 Funeral H	ome, P	.A.	Pennsylvania
attending physician and for use as the burial-transit authorise.	disease or concresulting in deal Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated ever resulting in deal	conditions, o immediate nderlying or injury	b. — Due to (or a	s a consequence		je v					
the hed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day		
be o	Part II. Other si	gnificant condi	tions contributing to death	but not resulting ir	the underlyin	g cause give	en in Part I.		tobacco use	57	o the cause of death? robably 4  □Unknown
								24a. Was auto perfo 1∐ Yes		prior to death?	utopsy findings available completion of cause of
n, After this certificate funeral director, pag	25. Was case re examiner?	eferred to medic	Hospital: 1 Inpa	tient 2 ☐ ER/Ou	tpatient 3□	DOA Othe		ath <i>(Check only o</i> Home 5 <b>X</b> Resi		□Other (Spe	ecify)
rs after death.  ral Director: After this certification: To Be C	27. Manner of D  1 Natural 2 Accider 3 Suicide 4 Homicio	5 ☐ Pend inves 6 ☐ Could	tigation d not be 28e. Place of in		Fime of njury M rm, stre <i>e</i> t, fac		yat k? Yes 2∐No	28d. Describe  28f. Location ( City or To	Street and		ural Route Number,
Fune Fune stely fill	29a. Certifier (Check only one)		ring Physician: To the bes al Examiner: On the basis and manner:	of examination an							
within 2 To the comple	29b. Signature	and title of certif	Kam	a MI	)	29c. License	02210	2	_	5/11	th, Day, Year)
2	30. Name and a	Y	n who completed cause of	death (Item 23a)	Type, Print)	67	MARKET	- DR.	Ch.	arlati	te HI Mas

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Ethel Frances Davis 10:49 PM May 5. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick 3604 Cool Crest Drive Jefferson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🗷 F 87 215-14-7418 1920 Director Dec. 24 Virginia Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show rral", or items 23a or 28a-f shov Examiner must be rediffed at Frederick Jefferson Md. 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21755 United States 3604 Cool Crest Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No White If Yes, Give Year or Dates: Specify: Þ 3 ₩ Widowed 4 □ Divorced "natural" Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura any injury or other traumatic event, the "he circal once." 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Reese Runion Edward Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3604 Cool Crest Drive, Jefferson, Md. Roy R. Davis, Jr. Son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/9/08 Norbeck Memorial Cem. Olney, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 P. O. Box 5038, Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years mmediate Cause (Final End State Cirrhosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Electrodard of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the the within. 29b. Signature and title of certifier Regist State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05 **Physician** OI' 2008 12:20 A M Α. Elcock Alfred /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Hyattsville 6645 23rd. Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Yea 3/24/1951 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Jamaica 57 Director 218-66-4838 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ty⊡Yes 2 □ No "natural", or Items 23a or 28a-f st dical Examiner must be notified Director Prince George's Hyattsville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20782 6645 23rd Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumattc event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self employed Carpet Cleaner 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etheline Peters Vincent Elcock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6645 23rd Avenue Hyattsville, Maryland 20782 Naomi Elcock/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/9/2008 Silver Spring, MD Gate of Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 T Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? Yes X□No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. Director; 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 5/2/2008 MD15185

Registrar
DHMH 17 Rev 1/2001

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State

Baltimore, Maryland 21215-0036

Box 68760,

Division or Vital Records, P.O.

Washington, DC 20017

istrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

2008

NE

1160 Varnum Street,

31. Date filed (Month,

MAY 0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Hea  1- State Registrar  Certificate of Dec			Z 1111M	16578
			1. Decedent's Name (First, Middle, Last)		Reg 2. Date of Death	. No	3. Time of Death
1	Physici /Medic		Robert Filer		Month	Day Year	ZIOPM
Ž	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local			4c. County of Dea	
		×	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year   150		8. Date of Birth	Ame 1	tandel
ı	Funeral Director			ours Min.	6. Date of Birth (Month, Day, Y 12/30/19	ear) Co	hplace (State or Foreign ountry) Insylvania
	D		Usual Residence of Decedent		12/30/19	724 1 1 61.	
	arylar show d at	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M 28a-f notifie	Director	Maryland   Anne Arundel   Riva   10f. Zip Code		100	. Citizen of What Co	
	3a or		2766 Riverview Drive 21140		109	USA	ouridy.
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Hispan If Yes, specify Cuban, M	nic Origin? (Spec	cify Yes or No-	14. Race - Ame	
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☑ No So	pecify:	noan, cto.	Black, Whit	
ö	hours Itural	ed b	3 Widowed 4 Divorced Year or Dates: 1944–46	1	16	6b. Kind of Business	White
75	in 72 In "na Medic	plet	(Specify only highest grade completed)  (Give kind of work done during life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	g most of working	g	b. faile of beenings	maday
21	ed with	Completed by	12th Owner/Operator			<u>Televisio</u>	n Repair
and	be filled had be filled be even	Be	17. Father's Name (First, Middle, Last) Harry C. Fuller	Mother's Name	(First, Middle, Ma	ŕ	
ž	should nd Mer mark	丘	19a. Informant's Name/Relationship ( <i>Type. Print</i> ) 19b. Mailing Address ( <i>Street and P</i>	Number or Rural		Splett	Zin Code)
Baltimore, Maryland 21215-0036	nd 2 saith ar 27 is		Cherie E. Fuller/ Wife 2766 Riverview			-	•
ore,	es 1 a of He of Hem		20a. Method of Disposition 1			c. Location - City or	
ţĬŢ	Pag tment tant: I		4□Donation 5□Other (Specify) Lakemont Cemetery	5-8-		Davidsonvi	
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lieuwee 22. Name and Address of 2973 Solomon				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	uch as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
d	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				year
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P.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			Month	Day Year
<u>ر</u> م	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	equire en sig ould b	ted to			1 ☐ Yes	2 No 3 □ P	robably 4 Unknown
ecc	ne law r has be ge 2 sh	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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<u> </u>	/slcla	o Be	Hospital: Other:	Place of Death		ce 6 □Other (Spe	-:5.1
יס ר	ig Phy ter thi	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		8d. Describe how		Спу)
Sio	tendir eath. or: Af the fur	atio	1/Natural 5  Pending (Month, Day Year) Injury Work? 2  Accident investigation M 1  Yes 3  Suicide 6  Could not be 28e Place of injury. At home farm street factory office	2 □ No			
Division or Vital Records,	l or At after d Direct	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28	Bf. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier  (Check only (C	date and place, an	nd due to the cau	se(s) and manner a	s stated.
	To the H within 24 To the Fo	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License nun			I. Date signed (Mon	
	1 C 0	5		2 1		1 4	
•	4×3		30. Name and address of beyon who completed cause of death (Item 23a) (Type, Print)  Tay Rhee 9W Bestawe Re 5-	ule 300	Annapolo	M) 2140	\
	Sta		31. Date filed (Month, Day, Year) 32. Progistrar's Signature		- J		
	Registr	ar	MAY 0 6 2008 Street & Secret				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Cleopatra Franko May 1:00 a 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 303 Maiden Choice Lane Baltimore Apt. 235 BALTINOLE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Months | Days | Hours | Min. | Feb. 18, 19 Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1924 West Virginia 1 □ M 2 T F 235-24-6690 84 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Maiden Choice Lane Apt. # 235 21228 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 ∐Yes 2 ∑No Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Elementary/Secondary (0-12) College (1-4or 5+) Security Administration 12 Clerical Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Vasilakis Maria Tsamouka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Thomas Franko/Son 361 Ellenham Court Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Annunciation Greek 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore, MD Orthodox Cemetery of Facility 21. Signature of Funeral Service Life ee Barranco 495 Gov. Severna Park Funeral H Severna Park, MD 21146 23a. Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 40005 P14 D10 Va Due to (or as a consequence of) Sequentially list conditions, in the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 27. Manner of Chath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Matural 5 ☐ Pending investigation

The law requires that the death certificate be executed attending physician and for use as the burial-transi P.O. Box 68760, signed by the a Division of Vital Records, After this certificate has been s funeral director, page 2 should After this al or Attending Fafter death.
I Director; After din by the funers

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ir e Modical Examinaring to motified at

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

Certification: To completely filled in by To the Hospital within 24 hours a To the Funeral D Medical

Sharon 31. Date filed (Month, Day, Year)

6 Could not be determined

MAY 0 6 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gr-ack

29c. License number 038762

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

t 🕾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

gistrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 12:30 PM 05 2008 ROSE FORD 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Univ of Maryland Medical Conter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) 1□M 2점F Months Days Hours-220-50-9529 69 June 25, 1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Maryland Prince George's Glenarden 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9017 Glenarden Parkway 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: Specify 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Community Outreach Worker Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McKinley Holley Mary Windsor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenora Harper (Daughter) 8116 Allendale Drive, Landover MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 5/6/2008 Clinton, Maryland 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service Licenses atricia 9013 Annapolis Road, Lanham MD 20706 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AND DESCRIPTION APPROVED BY MEDICAL EXAMINER Immediate Cause (Final Mesenteric Ischemic Dezs disease or condition resulting in death) Due to (or as a consequence of): Fall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertenien 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 □Yes 2 No 2 No 25. Was case referred to medical examiner?
1 ★ Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 04/25/2008 Unknown PM 1 ☐ Yes 2 No 2 Accident Fell down stars 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician; The law requires that the death certificate be executed the burial-transi and P.O. Box 68760, attending physician been signed by the s should be detached t Division of Vital Records, page 2 s certificate

Be Completed by Physician/Medical 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Certification; To completely filled in by Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

the Medical

Item 27 is marke other traumatic

Important: If It any injury or o

**Physician** 

/Medical

**Examiner** 

Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene. In them 27 is marked other than "natural", or items 23a or 28a.

Baltimore, Maryland 21215-0036

Director

Funeral

Be Completed by

၉

Examiner

Hospital within 2

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADRIAN MAUNE 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

MAY 0-6 2008

29a. Certifier

S GREENE ST 22 32. Registrar's Signature

Home

and manner stated

MD

PZZZOG

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

5/1/2008

29d. Date signed (Month, Day, Year)

Lanhem

9017 Glenciden Pkny

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Charles Leroy Fischer, Sr. May 2008 10:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11337 Sword Rd. Williamsport Washington If Under 1 Year Birthplace (State or Foreign Country)
 Mary land 8. Date of Birth (Month, Day, Year) Nov. 23, 1934 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** Days Hours Months Director 73 Nov. 220-30-9136 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Washington Maryland Williamsport 10e. Street and Number 10f, Zip Code 10a, Citizen of What Country? by Funeral 11337 Sword Rd. 21795 12. Was Decedent Ever in U.S. Arroed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1953-1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes XXNo Specify: 1956 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Designer Label Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Walter Fischer Ambrose Ann ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11337 Sword Rd. Williamsport, Donna M. Fischer - Wife Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. XIX Burial 2 Cremation 5 ☐ Other (Speg Greenlawn Mem. Park May 8, 2008 Williamsport, Maryland Signature of Fureral Service Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part to the spease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 200 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as t attending p IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Junkhown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has r this certificate has ral director, page 2 autopsy performed? 1∐ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Desidence 6 ☐ Other (Specify) ို 1 | Yes 2 | 1√0 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete 1 a ath (Item 23a) (Type, Print) GHILL In

State Registrar

3. Date filed (Month, Day, Year)

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2008

32. Re

strar's Signature

COLD OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	-	artment o		and Me		giene Reg. No. 2 (	008	16582
	Physicia	_	1. Decedent's Name (First, Middle, Las Bonnie E. Fox	t)					2. Date of Dea 04-30		Year	3. Time of Death 22;59p M
,	/Medic Examin		4a. Facility Name (If not institution, give	s Hospital		Cheve	n, or Location o	of Death		4c. Count	•	
ji.	Funeral Director		5. Social Security Number 587-22-7484  Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		Min. 0	3. Date of Birtl (Month, Day 5 – 1 6 –	1 <sup>4</sup> 950	9. Birth	place (State or Foreign intry)
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	ctor	10a. State 10b. County		ty,TownorLo per Ma	rlbor						10d. Inside City Limits 1  Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Coo				10g. Citizen of	What Cou	intry?
	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notifled at	Funeral	12127 Open Vie  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 □ No		2077 Was Decedent If Yes, specify (	of Hispanic Ori Cuban, Mexicar			Bla	ck, White	
5-0036	2 hours af iatural", or ical Exam	by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	If Yes, Give Year or Dates: ucation	16a Dece	1 ☐ Yes 2 🔼	cupation	_		Speci	<sup>fy</sup> Blae Business/Ir	
1212	filed within 7 Hygiene. wher than "r ont, the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Antic	kind of work do DO NOT use re Jue Re	storat	ion		Privat		
Maryland	Men arke	To Be	17. Father's Name (First, Middle, Last) Tennyson Shedd				Rosa	Lee	Stewa			
	s 1 and 2 sho if Health and item 27 is me other traums		19a. Informant's Name/Relationship (7 Emilie F. Monro	e/Daughter	1212	7 Oper	n View	Lan	e Upp	er Mar	lbor	
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removat from State	cemetery, crei esurre	sition (Name o matory or other ction	Ceme.		08-08		n,MI	
Ба	permit. Page Department of Important: If any Injury or once.		21. Signature Funda Service Licen	3/1	_ 1	N.W 80	orth A	lve.	Balti	more,		
	Physician		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. FATAL C	ARDIA		dying, such as RHYTH		respiratory ar	rest,		Approximate Interval Between Onset and Death
9	/Medical Examiner	7.		b. Due to (or as a conse	NCER							
3760,	ate be executed hysician and the burial-transit	lical Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								-
O. Box 68	attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	tal death 3	⊒Ectopic pregn ⊒Other (specif					ate of deli	very Day Year
1	n requires that the de been signed by the s should be detached	by	Part II. Other significant conditions c	ontributing to death but not re	sulting in the u	nderlying cause	given in Part I	l.	23e. Did t			the cause of death?
I Records,		Completed							24a. Was autor perfo			topsy findings available completion of cause of 2  No
Vital	cian: sertific setor,	Be (	25. Was case referred to medical examiner?	Hospital:				e of Death	(Check only o	ne)		
Ö	Ing Phy After this uneral d	ion: To	1 Yes 27 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c.	Other: 4 Number	28		dence 6 DO		cify)
DIVISION	Il or Attend after death. I Director: / d in by the f	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, st ify)				8f. Location (S City or To	Street and Nun wn, State)	nber or Ru	ıral Route Number,
	To the Hospital of within 24 hours affication 24 hours affication of the Funeral Discompletely filled it	edical C		ysician: To the best of my kr niner: On the basis of examir and manner stated.								
	To th To th comp	Me	29b. Signature and title of certifier	//			cense number			29d. Date sign		
				/will	MA		5895	7		MAY	5,	2008
2	- (U)		30. Name and address of Frson who	11) 3001 +	tospita	Print) DK		CHE	VERLY	MAY M)	201	185
	Sta Registi		MAY 0 8 2008	32. Registrar's Sign	ature							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:48 AM Ted Femi 3 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Hospita Memorial umber lanc 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, 1 Year If Under 24 Hrs. **Funeral** 1₩ M 2□F 89 Aug. 26, 1918 Director Mary land 214-07-1766 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Allegany Yes 2 No Cumberland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 701 Furnace Street Apt. 334 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1XIYes 2 □ No 1944 If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced þ 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Stone Mason 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa (Bisignano) Femi Nazzareno Femi 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 106 Porter Street, LaVale, MD 21502 Rosalie Thomas Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem Gardens May 16 08 LaVale, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hafer Funeral Service, 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIOGENI Physician 1704 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ut): Examiner The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation (Month, Day Year) Injury 1 □ Natural 1 ☐ Yes 2 ☐ No neral Director: A 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of pertific Kan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOTOWN ROAD

DHMH 17 Rev 1/2001

State

Registrar

DAGARATNA

31. Date filed (Month, Day, Year)

MAN 32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Kekua Fish 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day 7, 2008 K. Fish William 1340 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Fort Washington Prince George's 1100 Thrift Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) DC 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Days Hours 09/10/1956 Director Washington 51 216-64-4792 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Charles Indian Head 1 Yes 2 X No MD or 28a-f show ntural", or items 23a or 28a-f sho aminer must be notified at once. Director 10f, Zip Code 10g. Citizen of What Country 10e Street and Number USA 18 Meadowside Court 20640 Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year 1974 Specify: white 3 Widowed 1 Yes 2 X No specify: 4 X Divorced <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours:
nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed Private Elementary/Secondary (0-12) College (1-4 or 5+) Industry marked other than electrician 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Elizabeth Harrison Harry Edmund Fish Be event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 677 19a. Informant's Name/Relationship (Type, Print) ۵ tant: If item 27 is or other traumation Kendall Fish/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, Burial 2 X Cremation 3 Removal from State River dale Crematory Riverdale, MD 5/12/08 Department of Important: I Donation 5 Other Specify Name and Address of Facility 420 H Street NE 21 of Funeral Service Licensee BK Henry Funeral Chapel Wash DC 20002 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Marcotic (morphine) intoxication Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED #25a,27,28a-f, perME,g879 5/22/08 TT attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? certificate h ector, page 2 No Yes 2 No 1 🗸 Yes After this certifi-funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other; Hospital: DOA Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient 3 Inpatient 2 2 1 V Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natura 1 Yes 2 XNo Pending Director: d in by the f 24 hours after death. Fnd 5/7/2008 Fnd 12:30 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide 1100 Thrift Rd. Fort Washington, MD To the Funeral D completely filled i determined (Specify) woods Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 8, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day

7 2008

Registrar's Signature

08-03489	
A1' BA'-	F1

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

AllCe	Mane Fian		State of Maryland / Department of Health and Me Certificate of Death	Reg.	No. 201	08 1658
Med	Physicia ical Exami	an/	Decedent's Name (First, Middle,Last)     ALICE MARIE FLANAGAN	2. Date of Death Month D May 7, 2008	ay Year	3. Time of Death 0800 hrs
Pa			4a. Facility Name (if not institution, give street and number)  Peninsula Regional Medical Center  4b. City, Town, or Locati Salisbury	on of Death	4c. County of Deat Wicomico	
	Funeral Director		217-84-9954 1 M 2XF 32 Yrs. Months Days Ho	ours Min. 8. Date of Birth(	Forei	rthplace (State or gn ountry) Maryland
	ind show any	ě	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10c. City Town or Loca			10d. Inside City Limits 1 X Yes 2 No
769	the Maryla 3a or 28a-f	Director	10e. Street and Number 610 E. Grove St 10f. Zip Code 19940		. Citizen of What Cou US	
	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If titem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Specify Cuban, Mexital Status 2 Married Forces? 1 Yes 2 No If Yes, Specify Cuban, Mexital Status 1 Yes 2 No If Yes, Specify Cuban, Mexital Status 1 Yes 2 No If Yes, Specify Cuban, Mexital Status 1 Yes 2 No Spe	can, Puerto Rican, etc.)	14. Race - Ame White, etc. Whi Specify:	nican Indian, Black, .te
	136 hin 72 hours a e. than "natura edical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9  16a. Decedent's Usual Occupation (6 during most of working life. DO N N/A		16b. Kind of Business	/Industry
	MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic eyent, the Medica	Be	John Flanagan A	ther's Name (First, Middle, Ma lice Smullen		
	MD 21 Id 2 should old 2 should olth and Me on 27 is ma aumatic ev	Ţ	19a. Informant's Name/Relationship (Type, Print)  Barbara Majors- sister  19b. Mailing Address (Street and 610 E. Grove St	, Delmar, DE		
	Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		20a. Method of Disposition  20b. Place of Disposition (Name of cemeter)  3 Removal from State  4 Donation 5 Other Specifix  21. Signature of Fine his river accepted  22. Name and Address of Fa	05/15/2008	Delmar,	
		-		ral Home, PO		Seaford, DE Approximate Interval
	Physician /Medical *xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Between Onset and Death
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Civic which lighted cause.			
	ecuted and transit	al Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			
	'60, ate be ex ohysician ne burial	Medical	IF FEMALE:  AMENDED #23a,27,828a-f, perME,8879 5/23/08 TT  23c. If yes, outcome of pregnancy		23d. Date of delive	ery
	Livision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hour after ceah. To the Funeral Director. After this certificate has been signed by the attending physician and completely fill of in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/I		ctopic pregnancy	Month	Day Year
	P.O. E	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		2 No 3 P	to the cause of death?
	Clivision of Vital Records, P.O. tell or Attending Physician: The law requires that the rafter ceah.  and Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach led in by the funeral director.	Completed	-	24a. Was a autops perforr	y prior to ned? death	
	al R inn: T sertifica sctor, pa	BeC	overminer?	eath (Check only one)		
	f Vit Physic er this ral dire	2	1 Yes 2 No Inpatient 2 V ER/Outpatient 3 DOA		Residence 6 Otto	ner:
	on o anding arth. rr: Aft he fune	tion:	1 Natural 5 Pending RNd 5/7/2008 Find 7 m am 1 Yes	<sup>2</sup> X No unk		
	ivision Aller de after de Directe din by din by	Certification:	3 Suicide 6 X Could not be determined (Spacky) found at residence	ng, etc. 28f. Location (S 107 W. Ph	treet and Number or ate) iladephia St	Rural Route Number, City Salisbury, MD
	the Hospita thin 24 hours the Funera	Medical Ce	4   Homicide   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date at (Check only one)   2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation, in my opinion, death of the control of the basis of examination and/or investigation.	nd place, and due to the cause	e(s) and manner as s	tated.
•	7. Will	Me	29b. Signature and title of contifier  29c. License nu  O.C.M.E		29d. Date signed (/ May 8, 2008	Month, Day,Year)
A	DOME		30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Ba	altimore, MD 21201		
	S Regis	tate strar				

Registrar

State

31. Date filed (Month, Day, Year)

MAY 0 6 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2008 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year Month **Physician** 10, 7:33A M May J. Norma Gregory /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Clinton
If Under 1 Year If Under 24 Hrs. Southern Maryland Hospital age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖸 F Yrs. Director 58 July 2,1949 OH 278-48-0367 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director Md. PG Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Funeral 3509 Silver Park Drive #303 20746 Race - American India Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Commerce Administrative Assistant 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Mary Clinkscales Prince Bess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3509 Silver Park Drive #303
Suitland Md. 20746
Place of Disposition (Name of cemetery, crematory or other place)

5/16/08 Cabble Gregory/husband 20c. Location - City or Town, State 20a. Method of Disposition 5/16/08 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Mem. Cemetery Suitland, Md. <sup>22. Name and Address of Facility</sup> Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md.20746 21. Signature of Funeral Service Licenses Danna 23a. Part. Inter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine claim cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Por Month 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR ACCIDENT Completed 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an performed 2 No 1 ☐ Yes 1 Yes 2 7 25. Was case referred to medical examiner?
1 ☑ Yes 2☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

certificate be executed Records, P.O. Box 68760, ed by the a detached f certificate Division or Vital Physiclan: the Hospital or Attending death.

with

within 72 hours after death

Baltimore, Maryland 21215-0036

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D40324 29d. Date signed (Month, Day, Year) MAY 10,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7503 SURRATTS ROAD, CLINTON, MARYLAND 20735 TERRY JODRIE, MD

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)



**ORIGINAL** 

To the Hospital c within 24 hours af To the Funeral C completely filled i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2008 5 7:15p Claudia Jeanean Gibbs May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Marlboro Prince George's 4 Bowden Court If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 ☐ M 2 ▼ F Trinadad Director 81 6/24/1926 228-74-5233 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f show notified at 10b. County 1 ▼ Yes 2 No Prince George's Upper Marlboro Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pe o filed within 72 hours after death with "natural", or Items 23a 20774 USA 4 Bowden Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) St. Elizabeth's Hospital <u>Forensic Psychiatric Tech.</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tem 27 is marked oth Be Henry Bonnell Laura Francis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Calvert St., Hyattsville, MD Chris Gibbs/Son If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5-14-08 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Censes 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic Cancer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No Ö ed by the 9☐Unknown 9 Unknown σ, signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 TYes 2□ No 1□ Yes 2√√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Division (Month, Day ospital or Attending hours after death. 5 Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital owithin 24 hours at To the Funeral D

31. Date filed (Month, Day, Year) #AY 0 8 2008

Mahrjkh Hussain, MD

29a. Certifier

(Check only one)

29b. Signature and title of

Medical

State Registra 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221 Mercantile Lane, Largo, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

5/6/08

20785

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiand		irtment <i>tificate</i>				giene Reg. No.	2008	1858	9
*	Physici /Medic		Decedent's Name (First, Middle, I  JIMMIE	Last) GALM	ON					2. Date of De	Day 30,	2008	3. Time of Death  5 20PM	
	Examin		4a. Facility Name (If not institution, g				4b. City,	Town, or l	Location of Death	,		unty of Death		
			DOCTOR'S HO		. // /	A 6 : 46 - 4 1	L If Under	ANHA	M If Under 24 Hrs.	8. Date of Bir		RINCE GI		
	Funeral Director		248-62-7277	1★7 M 2 □ F	(În yrs. las	Yrs.	Months	Days	Hours Min.	SEPT 2	y, Year)	9. Birthpi Count 10 SOUTH	ace (State or Foreign try) CAROLINA	k.
,	death with the Maryland ms 23a or 28a-f show r must be notified at	_	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits	_
9	ne Ma 8a-f s	cto		GEORGE'S		L	<u>ANHAM</u>						1 XYes 2 No	_
3-	with the	Dire	10e. Street and Number				10f. Zip					of What Count	try?	
3	eath rs 23	eral	6207 BRIGHTLEA :	DRIVE 12. Was Decedent E	ver in U.S.	13 V		0706	enanic Origin? (Sr	pecify Ves or No		SA Race - America	an Indian.	_
Pmm 36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		1	f Yes, spec		spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White, e		
5-0036	'2 hou natura Ical E	ted	15. Decedent's (Specify only highest of	Education		16a. Deced	lent's Usua	l Occupa	tion	lilaa	16b. Kind	of Business/Ind	ustry	
2	within 7 iene.  than "r	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	+)		PENTE		uring most of worl	Killy	GOVE	ERNMENT		
O PL	e filed al Hyg I other vent, 1	BeC	17. Father's Name (First, Middle, La	st)		OZIK	. 11111		18. Mother's Nam	ne (First, Middle	Maiden Su			_
MOC.	ould b Ment arked artic e	입	UNKNOWN						WILMA		LEE			_
$\mathcal{C}_{\alpha l  \mathcal{M}on}$ Baltimore, Maryland 21	und 2 sh alth and 27 Is n or traum		19a. Informant's Name/Relationship  JANIE GALMON/WI						nd Number or Ru A DRIVE		-		*	
ore,	of Hes of Her fitem		20a. Method of Disposition 1 ဩrBurial 2 ☐ Cremation 3	□Removal from State	20b. Plac	ce of Dispo: netery, cren	sition (Nam	e of her place	)	Date	20c. Locati	ion - City or To	wn, State	
J. F.	t. Pag tment tant: I		4 Donation 5 Dother (Spec	cify)	HARI	MONY			5/5/			VER, MAI		
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Lic	Trecle	M	A.	7474	LAND	OVER ROA		VER, M			
- 1			23a. Part1. Enter the disease, or co shock, or heart failure. List on							or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute	•		1 Inf	arct	ion					
	Examiner			Due to (or as a										
100	T A	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	conseque	nce of):								_
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Renal			ency							
68760,	ificate be executed g physician and as the burial-transit	edical E		d.	conseque	nce on.								
	± 00 €	Medi	IF FEMALE:	00 W										
P.O. Box	requires that the death cert een signed by the attending rould be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal d	eath 3	Ectopic pre Other <i>(sp</i> e				23d	. Date of delive Month	ry Day Year	
	res that the de signed by the a be detached f		Part II. Other significant conditions	•	t not resulti	ng in the ur	nderlying ca	use give	n in Part I.				e cause of death?	
Sorce		eted	_End Stage Liver	Disease							-		ably 4 2 Unknown	
Division or Vital Records,	The la ate has page 2	Completed by			-					24a. Was auto perfo 1∐ Yes	psy prmed?	prior to con death?	osy findings available npletion of cause of  2X No	
<u>K</u>	Physiclan: this certific	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Dea	th (Check only o	one)			
ō	Phys r this ral dir	- To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatier	nt 2 🔀 EF	NOutpatien  8b. Time of			4 LI Nursing H	ome 5 ☐ Resi 28d. Describe			")	_
ion	Attending r death. ector: After y the fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	ion (Month, Day		Injury	M	3c. Injury Work' 1 □ Y	? es 2 □ No	204. 20001120	non injury o	0001100		
Divis	i i i i i	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home. (Specify)	e, farm, stre	eet, factory,	office		28f. Location ( City or To	Street and N wn, State)	lumber or Rura	Route Number,	
	ne Hospital 124 hours a ne Funeral	Medical (	29a. Certifier 1 X Certifying I (Check only one) 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner state	examinatio	edge, death in and/or inv	occurred a vestigation,	at the tim in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) an date and pla	d manner as st ace, and due to	ated. the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifler					License		,		igned (Month, I		
	(		Val no	ial				000	6329	6	0	5-01	-08	
CF	- (3)		30. Name and address of person who Davech A. M	ichaels	eath (Item 2	3a) (Type, 1	Print)	Lac	K.Rd.	Lanh	cum, i	mD. á	20706	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2008	32. Registra	ır's Signatu	· She								

		í	For State of Maryland / Departmen  1 - State Registrar Certificate				giene Reg. No. 🔿	000	10500
P			1. Decedent's Name (First, Middle, Last)			2. Date of De	ath (	UUO	3. Time of Death
	Physicia /Medic		DORIS MARIE GEISBERT			May	4,	Year 2008	9:23 A M
786 476	Examin	_	4a. Facility Name (If not institution, give street and number)  4b. City,	Town, or L	ocation of Death		4c. Co	unty of Death	
1		2		EDER]				REDERI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months 7. Age (In yrs. last birthday) Months		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)		lace (State or Foreign try)
i.	Director		217-32-5311 70 Trs. Usual Residence of Decedent			Jan. 1	9, 193	38 Mar	yland
	/land		10a. State 10b. County 10c. City, Town or Location					1	0d. Inside City Limits
	Mar-f sh	ţċ	Maryland Frederick Frederick	ζ					1 ☐ Yes 2 📉 No
	or 28	Director	10e. Street and Number 10f. Zip	Code			10g. Citizer	of What Coun	itry?
	23a cust b		8350 Layton Court		1704			ed Stat	
	tems ter m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, specific process.	dent of Hisp cify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	s afte	by Fi	1 □ Never Married 2X Married 1 □ Yes 2X No If Yes, Give 1 □ Yes 3 3 □ Wildowed 4 □ Divorced Year or Dates:	2 <b>X</b> No	Specify:		Sp	ecify:	t o
15-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show thit, the Medical Examiner must be notified at	edt	15 Decedent's Education 16a, Decedent's Usua	al Occupat	ion		16b. Kind	Whi of Business/Ind	
215	s within 72 ho piene. r than "natul the Medical	Completed	(Specify only highest grade completed) (Give kind of wo. life. DO NOT us	rk done du se retired)	ring most of worki	ng			
_	d with giene gr tha the l	mo;	+2 Secretar	<u>-</u>				Governm	ent
9	2 a a	Be	17. Father's Name (First, Middle, Last)	1	8. Mother's Name	(First, Middle	Maiden Su	rname)	
Ma	should be I nd Mental I marked oi matic eve	2	Bernard Warrenfeltz			Stup			
Maryland 2	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address	•			_		
	es 1 and 2 should bof Health and Ment fitem 27 is marked rother traumatic e		R. Hood Geishert, III / Husband 8350 Lay 20a. Method of Disposition (Nan	ton (	Court, I	Frederi		21704 tion - City or To	
Baltimore,	Pages nent of H int: If ite		1 Burial 2 Cremation 3 Removal from State						Maryland
<u>=</u>	it. Pe	1	4 □ Donation 5 □ Other (Specify)		-6 ==-111				
ga	permit. Page Department Important: If any Injury or once.		N/4 1 - C1 11		51			ral Hom	
			23a. Part . Enter the disease or complications that daused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	de of dying,	sumtown , such as cardiac	or respiratory a	rrest,	CICK, M	Approximate
	Physician	1 16						- 5	Interval Between Onset and Death Months
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Primary Perione of the to (or as a consequence of):	a ec	arcino M	1610212		-	- HIONIND
	Examiner		Courantially list conditions						
	D #	ner	Due to lor as a consequence of:						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c						
60,	be ex cian a	Ê	Due to (or as a consequence of):						
98760	ificate be executed g physician and as the burial-transit	edical	d						
_	= D &	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy				230	d. Date of delive	erv
Box	atter after for u	ciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No					Month	Day Year
oj.	at the de by the a tached	Physician/M	9 Unknown						
o,	The law requires that the death cert ite has been signed by the attending agge 2 should be detached for use	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	cause giver	n in Part I.	23e. Did 1	tobacco use	contribute to the	he cause of death?
ğ	w require been sig should b	ed k	_ Clostridium Difficile			1 🗆	Yes 2□	No 3 ☐ Prob	pably 4 Unknown
Vital Records,	law re as be 2 sho	Completed				24a. Was	nev	24b. Were auto	ppsy findings available mpletion of cause of
<u> </u>		E O				perfe	2 No	death? 1 ☐ Yes	
II.a	slcian: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Deat				
	Physic this c	은	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DC		4   Nursing no	-			(y)
U N	ding F	ion:	M M	28c. Injury Work?	at ? es 2 □ No	28d. Describe	now injury o	occurred	
Division or	or Attend after death. Director: /	Certification:	3 Suicide 6 Could not be 280 Place of injury - At home form street factor			28f. Location (	Street and I	Number or Rura	al Route Number,
<u> </u>	pital or A	ertif	4 Homicide determined building, etc. (Specify)	,		City or To			
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred						
	he Hc in 24   he Fu pletely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, In my op	inion, death occur	red at the time	, date and p	iace, and due t	o ine cause(s)
	To the To the Complex of To the To the To	ž	Ebb. Olgrand of the transfer	c. License	number			signed (Month,	
)			Fauzi Rizvi, MD	MDD6	2180		Mo	ry 5,	2008
	(2)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fauzi Rizvi, MD 400 West 7th Street,	Fre	derick.	MD 2170		0 '	
	,	•	31. Date filed (Month, Day, Year)  32. Registrar's Signature	, 110		21/0			
	Sta Registi		MAY 0 7 2008 & Leave Mr. Jan	100 c					

DHMH 17 Rev 1/2001

**ORIGINAL** 

08-03543	
Dwight Grant	

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

200	8	7	6	5	9

	1- For State Certificate of Description		Reg. No		
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) DWIGHT GRANT	-	Date of Death Month Day Vlay 9, 2008	06161118	h
2.	, and the same of	City, Town, or Location of Death heverly		4c. County of Death Prince George's	
Funeral		1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		M/DD/YYYY) 9. Birthplace (State or Foreign WASH .	DC.
Director	579 70 3928 1 M 2 F 55 Yrs. 1		FEB. 4,	1953 Country SH.	
any	10a. State 10b. County 10c. City, Town or Location			10d. Inside City	
Maryland Maryland 28a-f show d at once.	D.C. WASHINGTO			1 X Yes 2	No
C fife the	1825 SAVANNAH ST., S.E. #202	20020		Citizen of What Country?	
r death with or items 23 must be no	1 X Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Ongin? ( Spec specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - American Indian, Blac White, etc.	k,
s after der ral", or i iner mu	1 Yes 2 X No 3 Widowed 4 Divorced or Dates:	s 2 X No specify:		SpecifyBLACK	
natura Samii	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's l	Jsual Occupation (Give kind of wor of working life. DO NOT use retired		. Kind of Business/Industry	
5-0036 led within 72 hours at Hygiene. other than "natural the Medical Examin Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2  PLU	MBER		PRIVATE	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) MURRAY GRANT		JOHNSON	J	
AD 2 sho 2 sho rand 27 is mati	19a. Informant's Name/Relationship (Type, Print )  JULIA GRANT/MOTHER  19b. Mailing Action 19b. Mailing Ac	ddress (Street and Number or Run ST., N.E. WAS	SH. D.C	. 20002	
ore, M es 1 and 2 of Health If item 2'	20a. Method of Disposition  1 K Burial 2 Cremation 3 Removal from State crematory or other			c. Location - City or Town, State	
Baltimore, permit. Pages 1 a Department of He Important: If ite	4 Donation 5 Other Specify:		,, 00	LANDOVER MD.	
Baltimo permit. Page Department o Important: injury or ott		e and Address of Facility  ISON F. H. 343			
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the refailure. List only one cause on each line.				
/Medical 	Immediate Cause (Final disease or condition resulting in death)  a. Chest injuries  Due to (or as a consequence of):			Deat	n .
_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
miner	cause. Enter Underlying Cause (Disease or injury that initiated				
cecuted nand transit transit	events resulting in death) Last				
760, cate be exer physician a he burial -	W UNPENDED #AMENDED . 27 & 28a-f, perME, 8	3879 5/23/08 TT			
8760, tificate by ng physic as the burnar in/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	death 3 Ectopic pregnand		23d. Date of delivery  Month Day Y	′ear
). Box 68760, the death certificate be executly the attending physician and cooked for use as the burial - trapper Physician/Medical	past 12 months?  1 Live birth 2 Fetal 4 Pregnant at time of death 5 Other	(Specify)	cy	Month Bay .	
Box 68 he death certi the attendin hed for use a	1 Yes 2 No 9 Unknown 9 Unknown	-4.	Didustra	A second of de	anth?
ires that the signed by I be detach	Condignosaly and left ventricular hypertrophy		1 Yes 2	cco use contribute to the cause of de 2 No 3 Probably 4 V	
ds, equires een sig	Cardiolegary and left ventricular hypertropin		24a. Was an	24b. Were autopsy findings	
Vital Records, lysician: The law requires his certificate has been significate, page 2 should be Ompleted o Be Completed			autopsy performe		No No
II. The rifficat or, pag		26.Place of Death (Check or			]
f Vital Physician: r this certinal director	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3			sidence 6 Other:	
Afte funes	27 Manner of Death 28a Date of Injury 28b Time of Injury		28d. Describe how subject dri rehicular a	ver of venicle in	
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	2 X Accident 3 Suicide 6 Could not be determined (Specify) roadway	factory, office building, etc.	28f. Location (Stre	et and Number or Rural Route Num ) Minnesota Ave. SL & ston, DC	ber City v C St
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		d at the time, date and place, and o	due to the cause(s	) and manner as stated.	
To the Ho within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month, Day, Year)	
	The MIN TO	O.C.M.E.	VE V	May 10, 2008	
	30. Name and address of person who completed cause of death (Item 23a)	44 Dans Street Baltiman	MD 24204		
	The Book of the Control of the Contr	11 Penn Street, Baltimore	, NID 2 1201		
State Registra	4 4 4 0000 %				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician		1. Decedent's Name (First, Middle,	Last)		08 <i>Cler</i>				2. Date of D Month			3. Time of Death
/Medica			son Gray	7	1				MAY	2	2008	
Examine	er	4a. Facility Name (If not institution, UPPER CHESAPEAR		מיביחואי		4b. City, Tow		on of Death	1	4	tc. County of Dea HARFOR	
uneral				(In yrs. last	birthday)	If Under 1 Ye	ear If Un	der 24 Hrs.	8. Date of Bi	rth		thplace (State or Forei
rector		219-36-5357	¹ <b>X</b> M 2□F 67	7	Yrs.	Months Da	ys Hou	rs Min.	5/30/	194	O M	aryland
		Usual Residence of Decedent  10a, State 10b, County		10c. City, To	own or Loc	cation						10d. Inside City Limi
dkai Examiner must be notified at	ō	Maryland Cecil			y Po							1 <b>X</b> Yes 2 □ N
non .	Director	10e. Street and Number		Perr	у РО.	10f. Zip Cod	le			10g. 0	Citizen of What Co	ountry?
ed ist be		Broad Street				21	.902				USA	
5	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. V	Vas Decedent Yes, specify	of Hispanic Cuban, Mex	Origin? (Sparican, Puerto	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit	
gamil	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🏿 Divorced	1 Tyyes 2 □ No If Yes, Give Year or Dates: M	) arine	_ 1	□Yes 2⊠X	No Spe	cify:			Specify:	white
3	ed	15. Decedent's	Education		Sa. Deced	ent's Usual O	cupation			16b.	Kind of Business	6,6747
	be	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	,	(Give l life. E	kind of work do OO NOT use re	one during i tired)	most of wor	king	1		
	Completed	12	-		_ele	ctricia					electric	al
even d	Be	17. Father's Name (First, Middle, L Oliver Hayman (	•						ne (First, Middle an Anna		, and a second	
in F	၉	19a. Informant's Name/Relationshi		1	9b Mailin	a Address (Str					y or Town, State,	Zip Code)
other traumatic		Sheila Bradford	, ,,			•					D 21804	Lip Godo,
		20a. Method of Disposition				sition (Name o		1	Date		Location - City or	Town, State
		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (Sp				Cremat		5/5	/08	s	alisbury	, MD
any injury o		Signature of Funeral Service L	nsee	CFSP	22 H	Name and Ad OILOWA	dress of F	eral E	Home Pro	ofes	ssional A	Association 304
C 2	H	Ovice 9	o Dompse	70	5	01 Sno	W Hil	l Rd.,	, Salis	oury	7, MD 218	3O4 Approximate
		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line		o not ente	er trie mode of	dyllig, suci	i as caldiac	or respiratory	arrest,		Interval Between Onset and Death
ian cal		disease or condition resulting in death)	a. SEFSI Due to (or as a	consequence	ce of):							<del>1017</del>
er		O and a Market Bark and Millians	- R 1619T	LEG		CHER	MIA				Office	2 DAYS
1 .	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequent	or of):		. 207			V MEDY	CALEXUNER	
-fran-	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence		RACT	UKE	mo M	ON POP OVED	91	_	2017
s the burial-transit	<u> </u>		d	•	,			CERTIFICA	. 60]	سا	CALENDINER	
66	edical		u									
for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pt 1 ☐Live birth 2			lEctopic pregn	ancy				23d. Date of de	
3 7 7	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death	n 5	Other (specify	/)				Month	Day Year
σ.\ι.		Part II. Other significant condition	s contributing to death but	not resulting	g in the ur	nderlying cause	given in P	art I.	23e. Did	tobacc	o use contribute t	o the cause of death?
	d by			_	•				1	] Yes	2 □ No 3 □ P	robably 4 DiUnkno
Should	Completed								24a. Wa		24b. Were a	utopsy findings availal
page 2	E								per 1⊟ Yes	opsy formed′ 2 <b>.⊼</b> .	? death?	completion of cause of s 2 □ No
ō c	Be	25. Was case referred to medical examiner?	11					lace of Dea	th (Check only	one)		
<u>_</u> €	2	1) Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		Outpatien			Nursing H			6 ☐Other (Spenjury occurred	ecify)
fune	tion	1 S Natural 5 Pending 2  Accident 5 Pending	28a. Date of Injury (Month, Day) tion Fnd 4/30/20	Year)	Injury		Injury at Work? 1	2 🛐 No	probab1			
9	Hica	3 Suicide 6 Could no 4 Homicide determin	t be 280 Blace of injur	y - At home				A				oint Medical
2	Certification:	4 Enonicide	Hospital	(Specily)					Center	Perr	y Point, M	D Edicar
ely fill		(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of e	examination								
completely filled in by	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		29c. Lic	ense numb	oer		29d I	Date signed (Mon	th Day Year)
Comple	-	0 1 **	CAILMA IM.	1		1						-
		30. Name and address of person w	ho completed cause of dea	ath (Item 23	a) (Type,	Print) Pati	icial	ENSNA	500 W	Pro	Chocanoi	IKO Daise
91		Voker Cherapes	Le Medical	Cen	HEL	Bel	ALE	Ma	ylan	X	21014	/
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Registrar

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MD 20646 YAHIA M. TAGOURI

and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** May 2, 2008 Raymond Allison Hicks 5:49 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 DC 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 1X M 2 □ F 59 Director 579-62-4307 Dct.15,1948 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5018 13th St. NE 20017 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: o. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4or 5+) Librarian Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Jackson Raymond Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5018 13th ST. NE, Washington, DC 20017 Brenda L. Hicks/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Lincoln Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. H. pluane Ch. 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Months a Cirrhosis of the liver disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Alcoholism Years Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Peptic Ulcer disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Type II performed? Yes 2⊠No Hypertension 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🔣 Inpatient 2 ER/Outpatient 3 DOA မ funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the within To the complex

State 31, Date filed (Month, Day, Year)
Registrar MAY 0 6 2008

30. Name and address of person w

Dr. Ira Rabin

32. Registrar's Signature

impleted cause of death (Item 23a) (Type, Print)

D0061887

Holy Cross Hosp., 1500 Forrest Glen Rd., Silver Spring, MD 20902

May 5, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 ALICE MAY 7:15A HYDE MARJORIE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 13009 MARTIN ROAD PRINCE GEORGE'S BRANDYWINE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 🗷 F NOV.13,1917 MARYLAND Director 90 218-54-5878 Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No PRINCE GEORGE'S BRANDYWINE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U . S . A .

14. Race - American Indian, or Items 23a 13009 MARTIN ROAD 20613 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: à 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Q FARMER FARMING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT CROSS GRACE ESTELLE DEVAUGHN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health an PEGGY LLOYD/DAUGHTER 9207 DANGERFIELD RD. CLINTON, MD 20735 ortant: If item 27 Injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of ⊦ 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department o Important: If any Injury or once. ST.PAUL'S CH.CEM. 17, 2008 BADEN, MARYLAND 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL . HME . 21. Signature of Funeral Service Licensee 90 RAYMOND FUNL.HME., P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <3 WEEKS PNEUMONIA /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE >5 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed YEAR CHRONIC ATRIAL FIBRILLATION and Due to (or as a consequence of) P.O. Box 68760, attending physician PLEURAL EFFUSIOUS WEEKS Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an CONGESTIVE HEART FAILURE autopsy performed? 1□ Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical ExamIner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the 29c. License numbe 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 2008 D042049 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14314 OLD MARLBORO PIKE UPPER MARLBORO, MD ALAIN G. CHAMPALOUX M.D. 14 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2008 16597

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نامطنا	Neurotta 1 December 1 Name / First Middle Last) 2 Date of Death 3 Time											3. Time of Death 1541 hrs	
Medical Examiner PETER ERIC HASSELL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. Court										unty of Deat			
			4a. Facility Name (if not institution, give street and number)  Prince George's Hospital Center		41	Cheverly	ocalion 0	. Deadl			ce Georg		
	Funeral			yrs. last birthday)	<u>L</u> .	If Under 1 Year	If Under	24Hrs.	8. Date of Bir	th (MM/DD/Y		rthplace (State or	
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and the same of	ms 2.7	eral	11. Marital Status 12. Was Decedent Ever Armed Forces?			Decedent of Hisp					Race - Ame White, etc.	rican Indian, Black,	
	ld be filed within 72 hours after death with the Maryland fental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Funeral	Never Married 2 Married 1 X Yes 2	No					,			A CIT	
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21215_003E	be fill ntal H rked	Be	PETER HASSELL			E	STHE	R M.	ANDER	SON			
	should and Me 7 is ma	5	19a. Informant's Name/Relationship (Type, Print )		-	Address (Street				-		e, Zip Code)	
2	permit. Pages I and 2 should be file to Permit. Pages I and Aental Important: If item 27 is marked injury or other traumatic event, it		ESTHER M. HASSELL/MOTHER			tion (Name of cem			RGO, M.			r Town, State	
9	ss l ar of Hea If ite her tr		20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State	crematory or			1.1				•		
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Baltimore	ermit. Separt mpor njury		21. Signature of Funeral Service Licensee			ame and Address							
		Н	23a, Part I. Enter the disease, or complications that caused the c			74 LANDO						Approximate Interval	
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ä			23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at time	of dooth		tal death 3	Ectopic	pregnan	icy	Мо	nth	Day Year	
200	e death cer the attendi ed for use	Physici	1 Yes 2 No 9 Unknown 9 Unknown	or death 5	Oth	ner (Specify)							
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ý	tending Pheath.		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time	of Ir	njury 28c. Injury	y at Work	?	28d. Describe	how injury	occurred		
2	tendily eath. lor: / the fu	ije	Natural 5 Pending Fnd 5/11/20	008 unk		1 Y	es 2 X	No	unk				
	ipital or Att ours after do neral Direct	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury				uilding, et	c.	28f. Location or Town,		Number or F	Rural Route Number, City	
Ċ	24a. Was an autopsy performed? Input to death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28. Place of Injury  28. Location (Street and Number or Runy)  28. Place of Injury  28. Place of									per MArlboro, M			
	To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only one)  Certifying Physician: To the best of my known one)  Certifying Physician: To the best of my known one)  Medical Examiner: On the basis of examination	owledge, death oc	cur	red at the time, dat	te and pla	ace, and	due to the cau	se(s) and m	anner as st	ated.	
	To the Ho within 24 To the Fu	Medical	and manner stated.	don and/or mivest	gui	29c. License							
_	15	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Date of Certifier)  O.C.M.E.  May 12, 2008										ioinii, Day, reary	
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)			<ol> <li>Name and address of person who completed cause of death Zabiullah Ali, M.D. Assistant Medical Exam</li> </ol>	/	en	n Street, Balti	more. f	MD 212	201				
		tate	31. Date filed (Month, Day, Year) 32. Registrar's Si		c ·		-, .						
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			military and a second	ODIO!					UUI	VIE			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHERRY BISHOP JOHNSON Mar 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 21 F 96 NOVEMBER 24, 1911 NORTH CAROLINA Director 244-68-6630 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28e-f show 1 ▼Yes 2 □ No Funeral Director NONE. NONE WASHINGTON. D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 1743 D STREET, S.E. 20003 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: þ If Yes, Give Year or Dates: Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) 8TH GRADE FARMER FARMING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULE BISHOP NEALIE COX BISHOP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n eny Injury or other traun once. OPHELIA WILLIAMS /GRANDDAUGHTER | 11613 SILVERGATE LANE, BOWIE, MARYLAND 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SANDY BRANCH/KELFORD CEM. MAY 12,2008 ROXOBEL, NORTH CAROLINA 4 Donation 5 Dother (Specify) 21. Signature of Funeral Solice Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 TERRENCE L. JOHNSON M00993 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine onsequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Be Completed Certification: To

certificate be executed burial-tran Division or Vital Records, P.O. Box 68760. physician the

ted				1 Yes 2 No 3 Probably 4 Unknown						
Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No								
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)						
2	1 Yes 2 No	Hospital: 1 Inpatient 2 EP/Outpatient 3	e 5 ☐ Residence 6 ☐ Other (Specify)							
Certification:	27. Manner of Death  1 ★ atural 5 Pending  2 Accident investigation  3 Suicide 6 Could not by		Work?	8d. Describe how injury occurred						
Certific	4 ☐ Homicide determined	building, etc. (Specify)		Bf. Location (Street and Number or Rural Route Number, City or Town, State)						
edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
2	29h Signature and title of certifier		29c License number	20d Data signed (Manth Day Vara)						

(Check only 29b. Signature and title of certifier

29c. License number MDD53718

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8118 Good Luckld., Larham, MD. 20106 Thomas M. Hansson 31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	-		Registrar  1. Decedent's Name (First, Middle, La	ust)				2. Date of Dea	ath	V	3. Time of Death	_
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	/Medic Examin	0.00	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death		
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	Bla	ce - Americ ack, White,		
2	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Spec	ify: Whit	t e	
212-0030	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		15. Decedent's B	Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of			
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	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown									
P. 0.	w requires that the deben signed by the should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	s contributing to death but not r	resulting in the	e underlying cause gir	ven in Part I.	23e. Did	23e. Did tobacco use contribute to the cause of death?			
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	pital ours a erai D		29a. Certifier 1 Certifying	Physician: To the best of my	knowledge, d	eath occurred at the t	time, date and place	e, and due to th	e cause(s) and	manner as	stated.	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	edical	(Check only 2 Medical Ex	caminer: On the basis of exam and manner stated.	nination and/o	r investigation, in my	opinion, death occ	curred at the time	e, date and plac	ce, and due	to the cause(s)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** A M ERIC ARDELL JOHNSON MM 12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex Months Days Hours 1 X M 2 □ F Pennsylvania 218-68-7576 51 6/3/1956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Delta PA York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 17314 213 Hollow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Aes, Give Year or Dates: 1974–81 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: Whjte 1 ☐ Yes 2 ☐ 📉 🗸 🗸 Specify. ₽ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Foreman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary P. Linkous Vincent A. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 213 Hollow Road, Delta, PA 17314 Marcia C. Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Fawn Grove Cemetery 5/16/2008 Fawn Grove, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sanatus of Funeral Service Ligensee 17314 Harkins Funeral Home, Inc., Delta, PA Approximate Interval Between Onset and Death art Enter the disease, or complications, or heart failure. List only one Do not enter the mode of dying, such as cardiac or respiratory arrest, In mediate Cause (Final Cardiac arrhy Th mia

Due to (or as a consequence of): 5min disease or condition resulting in death) Cardiac ischemia 1 odays Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner cardiac disease Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? snoking 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

**Physician** /Medical Examiner burial-trar JOHNSON, ERIC or Vital Records, P.O. Box 68760, attending physician for use as the buria

**Funeral** 

Director

show

than "natural", or Items 23a or 28a-f showth Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 Is marked any Injury or other traumatic ev

ate has been signed by the page 2 should be detached 

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 Homicide

29a. Certifier

29c. License number D29222 29d. Date signed (Month, Day, Year) May 12,2008

Katuryn Jamamoto 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Kathryn Yamamoto 31. Date filed (Month, Day, Year)

2008



State

08-03668 John Bassett Lynch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 | 660 | Certificate of Death Reg. No 1- For State 3, Time of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day May 13, 2008 2355 hrs Physician/ John Bassett Lynch, III Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester 6331 South Point Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) Foreign Country) 5. Social Security Number **Funeral** Min. Months Days Hours MD 7/10/1970 37 Yrs Director 1 XM 2 F 215-06-6069 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County 1 Yes 2 No Berlin Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Worcester 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 21811 6331 South Point Rd. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes white 1 Yes 2 X No specify: Divorced If Yes, Give Year Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry þ 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Hospitality Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Abbott Be John B. Lynch, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 6331 South Point Rd., Berlin, Lisa Lynch / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/17/2008 | Snow Hill, MD Makemie Churchyard 4 Donation 5 Other Specify. 22. Name and Address of Facility The Burbage Funeral Home 21. Signal re of Fun Service Licensee 108 William St., Berlin, MD 21811 implications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician Death ne cause on each line. Cardi no aly and concentric left ventricular hypertro hy Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X 4#598527,#1,perME,g879 5/30 /08 TT XUNPENDED attending physician for use as the burial -23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Year 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? his certificate has been signed by the director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 V Unknown þ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, prior to completion of cause of death? performed? 2 No 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 1 Be Other, Nursing Home 5 Residence 6 Other: Scene DOA Hospital: 1 Inpatient 2 ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 V Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 15, 2008 OCME O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year) MAY 16 32. gistrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

ORIGINAL

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Shirley Estelle Lacey  $Ma_y^{Month}12, 2008$ 1:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 6. Sex if Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F February 24,1936 Maryland 579-70-2515 72 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, a or 28a-f show the notified at 10a, State 10c, City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Maryland St. Mary's Chaptico Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23410 John Walter Lane 20621 ral", or items 23a Examiner must b USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced "natural", the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public School 8 of Health and Mental Hygie I Item 27 is marked other i r other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lee Morgan Anna Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernadette M. Combs / Daughter 23583 John Walter Lane Chaptico, Maryland 20621 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17. Sacred Heart Cemetery Bushwood, Maryland 2008 21. Signature of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examiner The law requires that the death certificate be executed burial-tra Due to (o Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of de 23b. Was decedent pregnant ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe After this certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

30. Name and address of

31. Date filed (Month

James P. Jarbo

of death (item 23a) (Type, Print)

Three Notch Road

24085

M.D.

29c. License number

Hollywood, MD 20636

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date Month 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 14 10a YO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS - MEMORIAL CAMPUS 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Months 1 □ M 2 □ F ΜD Mar 27. 1943 219-44-0588 65 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 ☐ No Cumberland MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 21502 USA 1025 Kent Avenue death v Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evamina. 1 ☐ Never Married 2 Married 1 □ Yes 2 □ Xo Specify Baltimore, Maryland 21215-0036 p< white 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-4or 5+) Hospital Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hallie I. Hill Robertson Millard D. Robertson, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 1025 Kent Avenue Cumberland Richard Markle husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/17/2008 MD Mt. Hermon Cemetery Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lily one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, of com-shock, or heart failure. List only Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) ardia ar /Medical Due to (or as a consequence of): Examiner Acute Mi Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and LADSIP Due to (or as a consequence of): physician s the burial Division or Vital Records, P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? □Yes 2 No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 1 🔀 Inpatient ျှ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 | Homicide To the Hospital within 24 hours a To the Funeral C 😡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

Muhammad

MAY 21

31. Date filed (Month, Day, Year)

Nacem

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

6

Dr

29c. License number

D006150

29d. Date signed (Month, Day, Year)

Ave Suit 204 Cumberland ND 21502

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. Baltimore, Maryland 21215-0036

**Funeral** 

Director

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit

State Registrar

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

5	Maryland Frederi	ck	Frede:	rick				1 XYes 2 No			
a Direc	10e. Street and Number 516 Grant Place			g. Citizen of What Co	untry?						
runeral Directol	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		13. Was Decedent of If Yes, specify Cub	Black, White	14. Race - American Indian, Black, White, etc.  Specify: White					
0	3√√Vidowed 4 □ Divorced	Year or Dates:		21.71	Specify:						
pe completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		Decedent's Usual Occu (Give kind of work done life, DO NOT use retire	during most of work	sing 1	6b. Kind of Business/	Industry			
ó	11			<u>Medical Sec</u>			Doctor's	Office			
e o	17. Father's Name (First, Middle, Last)				1	e (First, Middle, M	ŕ				
0	Dorsey S. Culle	r			Jane R	anneberge	er				
	19a. Informant's Name/Relationship (Ty Jean L. Munshour	City or Town, State, 2									
- (1	20a. Method of Disposition		20b. Place of	Disposition (Name of ry, crematory or other pla	ical i	Date 2	Oc. Location - City or	tion - City or Town, State			
	1 A Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		l	Olivet Cem	etery May			ck, MD			
ž	21. Signature of Funeral Service Licen	A . /	00255	<sup>2</sup> Keeney <sup>Ada</sup> 106_East			eral Home	21701			
1	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that caused the cause on each line.			Approximate Interval Between Onset and Death						
	disease or condition resulting in death)	Due to (or as a	consequence		ray						
	Cerabroves culor accedent										
ie.	Sequentially list conditions,										
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	3.									
	resulting in death) Last	Due to (or as a	consequence	of):							
ca		d									
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf		3 □Ectopic pregnanc	74		23d. Date of del				
iysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at til 9□Unknown		5 ☐ Other (specify)	· y		Month	Day Year			
7	Part II. Other significant conditions co	ntributing to death but	not resulting ir	n the underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
ed by	Hypertie	nsin			1 □ Ye	Yes 2 0 3 Probably 4 Unknown					
Completed				-	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of				
20	25. Was case referred to medical					ZXNo 1 ☐ Yes	2 No				
ğ	ovaminor?	Hospital:	26. Place of Death (Check only one)  Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
	27. Manner of Death	28a. Date of Injury	28b.	Time of 28c. Inju			ciry)				
ation	1 Natural 5 Pending investigation	(Month, Day		njury Wo	rk? ]Yes 2∐No	28d. Describe how injury occurred					
erillo	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	/ - At home, fa (Specify)	rm, street, factory, office	28f. Location (Str City or Town	ation (Street and Number or Rural Route Number, or Town, State)					
Medical Certification:			xamination an	e, death occurred at the today. In my							
3	29b. Signature and title of certifier			29c. Licen	se number	29	29d. Date signed (Month, Day, Year)				
	1 Custin	Lear	ve	D	0968	7	5/15	108			
	30 Name and address of person who co	mpleted cause of dea	th (Item 23a)	(Type Print)			1				

Austin Pearre, M.D., 300 West Ninth Street, Frederick, MD 21701

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh g8795-30-08 yt
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryl		rtificate of			Reg. No.	2008	1660	
	Physici:		1. Decedent's Name (First, Middle, La Robert Kenneth					2. Date of De Month May 1	Day	Year 08	3. Time of Death 7:30p M	
	/Medic Examin	2	4a. Facility Name (If not institution, given			4b. City, Town, o	or Location of Death			County of Death		
			10051 Doctor Pe				sville			ederick		
	Funeral Director	y.	213-64- <b>34-1</b>	Sex 1 M 2 □ F 7. Age (In 53	yrs. last birthday Yrs.	If Under 1 Year   Months   Days	Hours Min.	8. Date of Bi	1 954	9. Birth Cou Mary	pplace (State or Foreign untry) Land	
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside City Limits	
	Marylis f sho ed at	ō	Maryland Frede	riok				1⊕Yes 2□No				
	the 128a-	Director	10e. Street and Number	LICK	Ijams	10f. Zip Code			10g. Citiz	en of What Cou	untry?	
	3a or		10051 Doctor Pe	rry Road		2175	54		Unit	ed Stat	es	
	ms 2	Funera	11. Marital Status	12 Was Decedent Ever	in U.S. 13.	Was Decedent of I		pecify Yes or N		4. Race - Amer Black, White	ican Indian,	
215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes		1 ☐ Yes 2 No		o moun, etc.,		C:	ite	
ဥ	72 ho natur lical	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dece	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wor	rking	16b. Kin	nd of Business/I	ndustry	
7	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	I .			ŭ	hio	-tech		
2	led w lygiel her th	ဒ္	17, Father's Name (First, Middle, Las	5+	OW	ner/opera	18. Mother's Nan	ne (First Middle				
anc	o = 0 >	Be	Robert Kennet	*				Lee Lo		•		
Maryland 2	should be nd Mental marked o	၉ ,	19a. Informant's Name/Relationship		19b. Mai	ing Address (Street					lip Code)	
<u>s</u>	and 2 sealth ar n 27 Is		Murray Mason /	brother		Catoctir			-		•	
<u>ē</u>	- T = =		20a. Method of Disposition	20	0b. Place of Disp	osition (Name of ematory or other pla	ace)	Date	20c. Loc	cation - City or	Town, State	
Ë			1. Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	_Hemovai from State	7/2008	7/2008 Lonaconing, MD						
Baltimore,	permit. Pag Department Important; I any Injury o		21. Signature of Funeral Service Lice		- 2	22. Name and Addre	ess of Facility Ke	eney 🖔 .	asfo	rd Fune	eral flome	
n	o a E c	0 2	gagaca	Kren MOI	L222	106 East	Church S	t., Fre	deric	k, MD 2	21/01	
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the one cause on each line.	death. Do not e	nter the mode of dy	ing, such as cardiad	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician	1	Immediate Cause (Final disease or condition	a lympho	oma						2 years	
<u> </u>	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):							
	LAAIIIIIlei Aaiiiiilei	_	Sequentially list conditions,	b Due to (or as a cor	nearmence of).							
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause posease or mjury that initiated events	Due to (or as a cor	isequence or).							
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):							
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_	= 0.0	/edi							-			
X R R	eath certifi attending for use as	an/N	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							3d. Date of deli Month	ivery Day Year	
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J.	ires that the de signed by the a be detached f										use contribute to the cause of death?	
Vital Records,	signe d be	d by	1 Vos 🏋 No. 2 🗆 Pro									
Ö	w requir been si should b	etec						24a. Wa	s an	24h Were au	Itopsy findings available	
Ď Y	The law cate has page 2 s	Completed						l auto	opsy formed? 2 X No	prior to c	completion of cause of	
<u>o</u>		e Co	25. Was case referred to medical				26. Place of Dea			1 ∐Yes	2□ No	
	rsician: s certificalirector,	o B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 [Inpatient	2 ER/Outpatie	ent 3 DOA Ot	har:	lome 512 Res		S ∏Other (Spec	cify)	
ō	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time			28d. Describe			,,	
5	Attending Physician: r death. ector: After this certific by the funeral director,	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	on	ar) Injury		Yes 2 No					
UIVISION OF	or Atter fter dea Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determined		28f. Location City or To	(Street and own, State)	d Number or Ru )	ural Route Number,				
	rrs ff											
	To the Hospitallor A within 24 hours after To the Funeral Dire completely filled in b	Medical		hysician: To the best of ma miner: On the basis of exa and manner stated.								
	To the To the To the Comp	M	29b. Signature and title of contifier				se number			e signed (Monti	h, Day, Year)	
)			X D			D 00	062234		05/1	3/2008		
			30. Name and address of person who					000			D 00050	
			Dr. Manish Agra			Center D	r., Suite	e 300, I	kockv.	лте, М	D 20852	
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 2 1 200	32. Registrar's		A 0						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mac **Physician** MUSE SR. JOSEPH PHILIP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC • 25 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Days 1 XM 1947 WASHINGTON, DC Director 60 220-50-5347 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 TYYes 2 □ No Director MD PRINCE GEORGE'S RIVERDALE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6825 RIVERDALE RD # A2 20737 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married ARMY Specify: BLACK 1 ☐ Yes 2 ◯XNo þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CHAUFFER 12th GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES MUSE CORRINE BROWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10836 BIG LEAF COURT WALDORF, MARYLAND 20603 LAMARIE BRUCE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2008 LANDOVER, MARYLAND HARMONY CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final VER **Physician** disease or condition resulting in death) /Medical Examiner UNG Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed burial-transi epatt to s Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical 241 the IF FEMALE: nse If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 2 No 1\_ 2 4 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death Check onl one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Thpatient 2 ER/Outpatient 3 DOA 10 funeral dir After this 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural death. 2 Accident 1 □ Yes 2 □ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CR 5

State Registrar Cecil D. George 7500 Hanover Parkwaii
31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAY 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Suit 101A Greenbelt, MD. 2012

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 2, **Physician** 2008 10:30pm<sup>M</sup> William H. Malachi /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 ☐ F Red Springs, NC 85 11/17/1922 Director 577-28-6805 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at tx Yes 2 No Directo Upper Marlboro Maryland Prince George's filed within 72 hours after death with the Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20772 3021 Squire Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Improvement Specialist Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental Hy tant: If item 27 Is marked oth Be Fred D. Malachi ٩ Dora Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3021 Squire Rd. Upper Marlboro Maryland 20772 Mary Malachi / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/13/2008 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) Maryland Veterans 21. Signatu of Funeral Service 22. Name and Address of Facility ope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 e, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 200 Physician disease or condition resulting in death) /Medical Due to (or as a c sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy led by the atter detached for u in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐ Yes 2☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mnknown Completed 24b. Were autopsy findings available prior to ∞mpletion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2 No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗐 Natural (Month, Day Year) Injury 5 ☐ Pending investigation , Safter dea., safter dea., seral Director: A\* 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cp (9)

State
Registrar

State

MAY 0 8 2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of N	raryian	-	tificate of	nealth and f Death	u Men	Re	g. No. 2	008	16	608
1	Physicia	an	1. Decedent's Name (First, M	-		Date of Death Month	Day Year			f Death					
(in)	/Medic	al	Nettie Edith M  4a. Facility Name (If not institute)	etroat and numbe	4b. City, Town,	11, 2008 4c. County of Death			3:25	P W					
45	Examin	er	49571 Airedele		Sireel and numbe	'/			idge	Oddii			St. Mar	v's	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 12 F 88					If Under 1 Yea Months Day	ar   If Under 24 h	lin. (	Date of Birth Month, Day, nuary 6	Year)	_	place (State ontry)	or Foreign
	w	ŀ	Usual Residence of Deceden 10a. State 10b. Cou			10c. City	y, Town or Lo	cation					1	0d. Inside C	ity Limits
	Maryla f sho led at	ō		st. Ma	rv! e				Ridge					1 ☐ Yes	2 No
	28a-	Director	10e. Street and Number	oc. na	1, 3			10f. Zip Code			10	g. Citizen o	of What Cour	ntry?	
	h with		49571 Airedele	Road					20680				USA		
	ems ?	Funeral	11. Marital Status		12. Was Deceder Armed Forces	nt Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin? uban, Mexican, Pu	? (Specify uerto Rica	Yes or No- n, etc.)		Race - Americ		
15-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ ☐ 3 🗷 Widowed 4 ☐ Divor		1 ☐ Yes 2 <b>∑</b> If Yes, Give Year or Dates	No		1⊡Yes 2⊠N				Spec		ite	
2-0	72 ho 'natur dical	Completed	15. Dece (Specify only hi	dent's Ed	ucation de completed)		16a. Deced	dent's Usual Occ kind of work dor	cupation ne during most of red)	working	1	6b. Kind of	Business/In	dustry	
2	vithin ne. han " e Me	d m	Elementary/Secondary (0-1		College (1-4o	r 5+)			red) rating Acc		nt D	epartm	ent of	the Nav	У
Maryland 2121	filed v Hygie ther t	ပ္ပိ	12 17. Father's Name ( <i>First, Mid</i>	dle, Last)			L		18. Mother's i	Name (Fir	st, Middle, M	laiden Surn	name)		
au(	ed all be	To Be	James Raub Drur						Ros	e Som	ers				
37	d 2 should be th and Mental 7 Is marked of traumatic ev	ř	19a. Informant's Name/Relat				19b. Mailir	ng Address (Stre	et and Number or	r Rural Ro	ute Number,	City or Tow	vn, State, Zip	Code)	
Š			Rose M. Carroll	/ Dat	ighter		P.O.	Box 191	Dameron,	MD 20	628				
Baltimore,	Pages 1 and 2 ment of Health ant: If Item 27 I ary or other tra		20a. Method of Disposition 1   Burial 2 □ Cremat 4 □ Donation 5 □ Othe					sition (Name of matory or other p		Date 7 16, 2008			n - City or To	,	
Baltii	permit. Pag Department Important: I any Injury o		21 Signature of Funeral Ser			7-	) 22	Name and Add Mattingl P.O. Box	ey-Gardine	r Fun	eral Homown, MD	ne, P.A			
			23a. Part . Enter the diseas	e, or comp	olications that caus	ed the deatl	h. Do not ent							Approxima	ite
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):										- 4	Approximate Interval Between Onset and Death  ICACS	
	Physician /Medical		disease or condition resulting in death)	-	a. Due to (or a	as a consequ	uence of):						-	7841	,
	Examiner				MY	201	tzusi	LV						Years .	
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	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		0.			-100	.,,,,,					264	
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68760,	ifficate be executed g physician and as the burial-transit	edical			.d										
Box	± Dig	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 No		23c. If yes, outcon 1□Live birth 4□Pregnant	2 🗆 Feta	Ideath 3[	Ectopic pregna					Date of deliv Month	ery Day	Year
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Vital Records,	The law requires that the death cer tte has been signed by the attendin bage 2 should be detached for use	Completed								_	24a. Was an autopsy perform	ned?	b. Were auto prior to co death?		available cause of
<u>ra</u>			25. Was case referred to me	dical					26. Place of	Death (C	1□ Yes 2 heck only one	No No	1 ☐ Yes	2□ No	
>	ysicia is cer direct	To Be	examiner?	Ì	Hospital: 1 Inpa	itient 2	ER/Outpatier	nt 3 DOA	Other:		5 Reside		Other (Speci	fy)	
0	ng Ph tter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pe	nding	28a. Date of II	njury Day Year)	28b. Time o Injury	f 28c. Ir	ijury at Vork?	28d.	Describe ho	w injury occ	curred		
000	endir sath. or: Af he fur	atio	2 Accident inv	estigation uld not be				M 1	☐Yes 2☐No						
Division or	al or Att s after de al Direct ed in by t	Certification:		termined	20e. Flace U	injury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, offic	ce	28f.	Location (Str City or Town	eet and Nu , State)	ımber or Rur	al Route Nui	mber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely illied in by the funeral director,	Medical (			ysician: To the be niner: On the basis and manner	of examina									(s)
	To the within To the comp	Me	29b. Signature and title of ce	rtifig/2\V	Odz J			29c. Lice	ense number	······	29	od. Date sig	ned (Month)	Day, Year)	
•	D.		30. Name and address of pe	son who	completed cause of	f death (Iten	n 23a) (Tune	Print)	WIII			0/10	-1000	0	
	43		Dha na njay		JSa.v	14035	Three	e Notch	Road	Holl	PUOLITA	MD	206	36	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea Physician May 2008 Myron Franklin McCartney 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Director 70 05/18/1937 477-40-7143 Minnesota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Directo Maryland | St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23735 Hicks Drive 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Emma Quade Delbert Eugene McCartney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara J. McCartney/Wife 23735 Hicks Drive, Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem | 05/16/2008 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) KEGIRATORY FAILURE **Physician** /Medicai Due to (or as a consequence of) OBSTRUCTIVE PULMENARY DISCAR **Examiner** YEARL CMINIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Dívision or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4⊡Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1□ Yes 2₽No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Franklin McCareney

State Registrar 29b. Signature and title of pertifier

P.O. Box M.D

Hellywood, Maryland 20636

29d. Date signed (Month, Day, Year)

5-11-08

Raibinder Gill, 31. Date filed (Month, Day, Year) MAY 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

1)56096

			For State	Maryland		rtment of He tificate of D			JIENE leg. No. 🐔	1000			
0			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th 6-	1000	3. Time of Death		
3-	Physicia		Virginia M. Martino					Month April	30, 2	Year 2008	09:40 AM		
	/Medic Examin	_	4a. Facility Name (If not institution, give street and nur	mber)		4b. City, Town, or I	Location of Death			ounty of Death	, 0, 1, 0 121		
	LAGIIIII	CI.	Calvert Manor Healthcar	e Center		Rising	Sun		Ce	eci1			
g + 6 y 7 8	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year)	9. Birthp	place (State or Foreign		
Ŀ.	Director		467-22-2063 1□M 2XF	83	Yrs.			April 27		25 Tex	as		
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City. 7	Town or Loc	eation				1	10d. Inside City Limits		
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	the N	Director	Jersey Camden 10e. Street and Number	Eria	а1	10f. Zip Code			10g. Citizer	n of What Cour	ntry?		
	with a or	ä	8 Fairmount Avenue			08081			Unite	ed Stat	25		
	leath ns 23 mus	era	11 Marital Status 12. Was Dece	edent Ever in U.S.	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-		. Race - Americ	can Indian,		
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumalic event, the Medical Examiner must be notified at once.	by Funeral	Armed Formula    2 <b>X_M</b> No ve		r Yes, specify Cubar I ☐ Yes 2/(∑/No	Specify:	nicari, etc.)	ı	Black, White, pecify: Wh	ite			
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D D	be file	Be Completed	17. Father's Name (First, Middle, Last)				18. Mother's Name			urname)			
Z	ould Nen narke	ဥ	Willie Joe Rost		405 34-115-	g Address (Street a		lae Gorn		Town State 7	n Cada)		
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)  Norma Lee / Daughter			rookview							
	is 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition	20b. Plac				Date		tion - City or T			
Baltimore,	Pages ment of P ant: If ite ury or o		1 N Burial 2 □ Cremation 3 □ Removal from	State New	netery, crer St. I	sition (Name of natory or other place Mary s	May 2	2, 2008	Belli New	nawr Jersey			
≣	artme ortan injun		4 □ Donation 5 □ Other (Specify)  21. Signature of Fulleral Service Licensee	Ceme		. Name and Addres		couch Fu					
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	Physician		Immediate Cause (Final	obran	1 -	= cula	~ Hc	cide	n+		Onset and Death		
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Cerebrar as Cular HC(dent unknown)  Due to (or as a consequence of):										
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	ires that the death certif signed by the attending d be detached for use as	Physician/M	In the past 12 months?  4 □ Preg  1 □ Yes 2 □ Not	nant at time of dea		Other (specify)				WORKI	Day real		
P.O.	at the	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to c	looth but not recult	ing in the U	nderlying cause give	en in Part I	23e Did t	obacco use	e contribute to	the cause of death?		
	requires that the een signed by th hould be detache	by	Part II. Other significant conditions continuating to c	eath but not result	ang mulo a	nderlying oxese give	or are a	10		7			
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or Vital Records,	2 28 2	Completed						24a. Was autop		prior to o death?	opsy findings available ompletion of cause of		
a	ician: The certificate ha ector, page		or W				00 81( 8	1□ Yes	2 No	1 □ Yes	2 No		
₹		o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	Inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Othe	26. Place of Deal	me 5 ☐ Resi		□Other (Spec	rify)		
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on	Attending Phr r death. ector: After thi by the funeral	iżi	1 Natural 5 □ Pending (Mol 2 □ Accident investigation	nth, Day Year)	Injury		Yes 2 □ No						
Division	l or Attend after death Director:	ifica	3 Suicide 6 Could not be 28e. Plac	e of injury - At hom ling, etc. (Specify)	ne, farm, sti	reet, factory, office		28f. Location (	Street and wn. State)	Number or Ru	ral Route Number,		
Ö	tal or / s after al Dire	Certification:						·			0		
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	ledical (	29a. Certifier 1 X Certifying Physician: To the (Check only one) 2 Ledical Examiner: On the and main a	basis of examination									
	the the omple	Med	29b. Signature and title of certifier	nner stated.		29c. Licens	e number		29d. Date	signed (Month	n, Daly, Year)		
	F × F 8				0	De De	2051	2449	4	1/30	108		
		7	Name and address of person who completed cau	ise of death (Item 2	23a) (Type.	Print) /	1	111		111			
	6	1	aleria Dimonsea	MD 11	1W.	High S.	t. Sur	te 30	2 E	Ktan	MD 21921		
	Sta	ate	31. Date filed (Month, Day, Year) 32.	Registrar's Signatu	ure						, )		
	Regist	rar	MAY 1 2008	Haran	K	Smell							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registrar Amend #2 perMD, g879 5/21/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** April 30,<del>3008</del> **2008** 7:45pm M Monroe /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Manor Care-Potomac Potomac If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Jathornho Day 1 921 7. Age (In yrs. last birthday) 9. Birthplace (State Bow 1'8), TX 5. Social Security Number 6. Sex **Funeral** 87 1 □ M 2 X F 446-01-1212 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Bethesda MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20816 5101 Lawton Dr Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental Hant; If Item 27 Is marked out Jury or other traumatic even Be Lois Anna Edward Lewis Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8903 Bells Mill Rd., Potomac, MD 20854 Ann Brown/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important; if ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 6,2008 Falls Church, Va National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Licensee Mail HODO 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the compact Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Vital Records, P.O. Box 68760 Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chronic Obstructive Pulmonary Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheral Vascular Disease 24a. Was an certificate has director, page 2: autopsy performed? 1□ Yes 2K No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To Division or this fureral 27. Menner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury 28h. Time of 28c. Injury at Work? Affler To the Hospital or Attending within 24 hours a er death.
To the Funeral Lirector: After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00054566 May 1,2008

To

State Registrar 31. Date filed (Month, Day, Year) MAY 0 5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For State Registrar	State of Marylan	•		of Health and N of Death		giene Reg. No. 🤉 🦳 (	00 10010
	E		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	3. Time of Death
	Physici /Medic		WILLIAM JER	·	HOLS			MAY		008 7:57 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give str CIVISTA MEDICAL	•		,	wn, or Location of Death PLATA		4c. County o	RLES
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1		8. Date of Birt	h, Year) 5,1943	Birthplace (State or Foreign Country)
E.	Director		218-40-0307	<sup>M 2□F</sup> 64	Yrs.	I VIOLITIES L	ayo Hodio iviini	OCT.2	5,1943	N.C.
	/land ow at		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits
	e Man la-f sh tiffed	ctor	MD. CHARLES				LA PLATA			1 ☐Yes 2 XXNo
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 5945 WINTERS DF	RIVE			0646		U.S.A.	•
396	J within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medisal Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Styles 2 □ No AR If tes, Give Year or Dates: 196	MV	Vas Deceden fYes, specify □Yes 2√√	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto l No Specify:	pecify Yes or No- o Rican, etc.)		e - American Indian, k, White, etc. : WHITE
21215-0036	nin 72 hou e. In "natura Medical E	Completed	15. Decedent's Educa (Specify only highest grade	ation completed) College (1-4or 5+)	(Give I life. D	OO NOT use i	done during most of work etired)	-	16b. Kind of Bu	
212	filed within Hygiene. other than "	Com	12	- Consider (1 101 CT)	EXPL	OSIVE				DIAMOND LABS.
Maryland	be od o	Be	17. Father's Name (First, Middle, Last) WILLIAM JOSEPH	NTCHOLS			18. Mother's Nam		DYS SPI	
aryl	S D E E	ပ္	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (S	treet and Number or Ru			
	nd 2		VERA NICHOLS-SPO				ERS DRIVE		<u>-</u>	20646
Baltimore,	SS C P		20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		Place of Disposemetery, crent FORD	natory or othe	er place)	16-08		City or Town, State  Re GRACE, MD.
Balt	permit. Page Department of Important: If any Injury or once.	0 90	21. Signature of Funeral Service Licenses	2	R.	AYMON A PLA	Address of Facility D FUNERAL TA, MARYLA	ND 206	46	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one		h. Do not ente	er the mode o	of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	+Scheme Due to (or as a conseq	Hence of:	vt.	Msey!			
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-	ertificating physe as th		IF FEMALE:							
.O. Box	he death certificate be executed the attending physician and shed for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	<ul> <li>c. If yes, outcome pf pregnance</li> <li>1 ☐ Live birth 2 ☐ Feta</li> <li>4 ☐ Pregnant at time of depth of the properties</li> </ul>	Ideath 3	Ectopic preg Other <i>(spec</i>			23d. Dat Mor	e of delivery nth Day Year
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ords	w require been sig should b							1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Dea			
9	ding Phys h. After this funeral dir	on: To	27. Manner of Death 1	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		4 □ Nursing H Injury at Work? 1 □ Yes 2 □ No		dence 6 Other	
Division	I or Attending after death. Director: Afte	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specification)				28f. Location (		er or Rural Route Number,
Ω	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Examin	ician: To the best of my kno er: On the basis of examina						
	o the lathin 2.	Medical	one)  29b. Signature and title of certifier	and majorer stated.		29c. l	icense number	T	29d. Date signer	d (Month, Day, Year)
	F 3 F 8		132	, 11	S	D	0033421	0	5/13/	08
			30. Name and address of person who cor	'/	n 23a) (Type,					
			JARRY Jew 31. Date filed (Month, Day, Year)	KINS M	ature /	.0				
	Sta Registi		\$1. Date liked (MONIN, Day, 1047)	Real B	ASSA					

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**ORIGINAL** 

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 6,2008 **Physician** Year 3:00pm M Luvern R. Neumann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. (Month, Days) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 104-12-3294 85 Sept. 13, 1922 Syracuse, NY Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo N.Y. Onondaga Syracuse Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13208 USA 300 Craig Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify: White Specify: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Diamond Inspector Jewelry it of Health and Mental Hygir If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Hollenbeck Robert Salisbury Pages 1 and 2 should I ပ္ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven R. Neumann/Son 185 Hastings Place Syracuse, N.Y. 13206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 10, permit. Page Department o Important: If any Injury or 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation \_\_\_5 □ Other (Specify) Syracuse, NY Woodlawn Cemetery 5 ☐ Other (Specify) 2008 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate ı∏Yes 2 or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Toto Hospital: 1 npatient 2 ER/Outpatient 3 DCA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 🗆 No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signature

| State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Registrar | State Regi

			For amended#31, St	ate of Maryland	/ Depa		lealth and I	Mental Hyg	giene	Die.	
· ·	Physici /Medic	-		ed Louise No				2. Date of Dea Month May	8, 2	008 2:	me of Death 50 A M
)	Examin Funeral	er	4a. Facility Name (If not institution, give street  22100 Bell Farm Way  5. Social Security Number  6. Sex	7. Age (In yrs. Ia.		4b. City, Town, o  Leonard  If Under 1 Year  Months Days		8. Date of Birth (Month, Day June 17	2	Mary's	itate or Foreign
	Director ts post	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary	10c. City,	Yrs. Town or Lo	cation	ardtown	June 1/	, 1924		d ide City Limits ]Yes 2X No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	eral Director	10e. Street and Number 22100 Bell Farm Way	for December 5 were in 11 S	42.5	10f. Zip Code	0650		10g. Citizen of 1	What Country? USA	an
5-0036	ours after de ural", or items I Examiner m	d by Funeral	1 □ Never Married 2 □ Married 1 1 3 Modern Married 4 □ Divorced Y	Vas Decedent Ever in U.S.  Irmed Forces?  ☐ Yes 2X No  Yes, Give ear or Dates:		1□Yes 2█ No		pecity Yes or No- to Rican, etc.)	Specif	ck, White, etc. fy: White	
21215-(	filed within 72 h Hyglene. vther than "natu ant, the Medica	Completed	10	npleted)	(Give life.	DO NOT use retire	during most of word) caregiver		Nu	rsing	
p	be file tal Hy d oth	To Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle,		•	
Maryla	d 2 should be filed w th and Mental Hygie 7 is marked other t traumatic event, th	으	George Franklin Guy  19a. Informant's Name/Relationship (Type. F Thomas Merle Norris				Ma Pand Number or Ri rm Way I		er, City or Town	, State, Zip Code)	
Baltimore, Maryland 2121	Pages 1 and 3 ment of Health ant; If item 27 ury or other tra		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Remore 4 □ Donation 5 □ Other (Specify)	val from State Cei	ce of Disponetery, cre	osition (Name of matory or other pla norial Gard	ce) May	Date 12, 2008	20c. Location	- City or Town, Sta	
Balt	permit. Page Department Important; II any Injury o		21. Signature of Funeral Service Licensee	Landener		P.O. Box 2	-Gardiner 70 Leonard	itown, MD	20650	Appro	
	Physician /Medical		23a. Part / Enter the disease, or / implication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Pun Co	ear	er the mode of dyl	17 ( ex	c or respiratory ar	rest,	Interve Onset	oximate ral Between t and Death
68760,	w requires that the death certificate be executed  been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conseque	W					2 3	42 42
Box	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	in the past 12 months?	f yes, outcome pf pregnan I □ Live birth 2 □ Fetal of I □ Pregnant at time of dea I □ Unknown	death 3	∃Ectopic pregnanc ∃ Other (specify) _	ey			ate of delivery lonth Day	Year
rds, P.0	quires that 1 en signed by uld be deta	by	Part II. Other significant conditions contributions of the Ponosi		ting in the u	nderlying cause gi	ven in Part I.			ntribute to the caus	
Vital Records,	S 53	Completed	25. Was case referred to medical				00 Plans of Pa	1□ Yes	osy rmed? 2 No	. Were autopsy fine prior to completio death?  1  Yes 2 N	on of cause of
n or Vit	To the Hospitallor Attending Physician: The I within 24 hours after death.  To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	on: To Be	examiner? 1	1   Inpatient 2   E	R/Outpatie 28b. Time o Injury	f 28c. Inju	her: 4 \sum Nursing I	ath (Check only conduction of the conduction of	dence 6 □Ot		
Division or	allor Atterio	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Be. Place of injury - At hon building, etc. (Specify)	ne, farm, st			28f. Location (	Street and Num vn, State)	nber or Rural Route	e Number,
	the Hospit nin 24 hours the Funera npletely fille	Medical (	(Check only 2 Medical Examiner: one)	n: To the best of my know On the basis of examinati and manner stated.		vestigation, in my	opinion, death occ		date and place	e, and due to the ca	
)	To with	2	29b. Signature and title of certifier	uhi		00	se number 0 6 622	13	5 8	ed (Month, Day, Y	oai)
-				50 Cedar Lane C	ourt		dtown, MD 2	0650			
			31 Date filed (Month Day Year)	32. Registrar's Signatu	ıre						

Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Margaret Theresa Olson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Prince George's Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct.25,1927 Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖾 F 80 Director 577-32-7262 Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6113 Roanoke Ave. 20737 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 

Widowed 4 

□ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housing Asst. Manager other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry C. Gill Pearl A. Stanton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6113 Roanoke Ave., Riverdale, MD 20737 Linda Vick/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 分 Cremation 3 ☐ Removal from State 5/9/2008 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crem. Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. H. Muane 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications but shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner LO MOS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed romo physician and as the burial-trans Due to (or as/ eval Failur steps Completed by Physician/Medical use as the attending ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 16 No 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) hed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 A Yes 2 🗌 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 talny certificate 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check only one Hospitat: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 21 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death / To the Funeral Director: A completely filled in by the fi death. investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl 0047861 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print) Oney Zuniga, MD 4701 Randolph Rd., Rockville, MD 20852 .31. Date filed (Month, Day, Year) State MAY 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore,

Division of Vital Records, P.O. Box 68760,

		_ FOr	Department of Health and M Certificate of Death	ental Hygiene				
	sician	1. Decedent's Name (First, Middle, Last)  Joyce Ann Osterwalder		2. Date of Death Month Day Year April 27, 2008 3. Time of Death 2:00 A M				
	edical miner	4a. Facility Name (If not institution, give street and number)  111 Johnson Drive	4b. City, Town, or Location of Death Salisbury	April 27, 2008  4c. County of Death Wicomico				
Funer Direct		211 02 0002 /3	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 2/5/1935 Maryland				
NTE, MATYIANG Z1Z15-UU36 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent  10a. State	alisbury	10d. Inside City Limits 1 □ Yes 2 □ No				
with the page 2	ä		10f. Zip Code 21804	10g. Citizen of What Country? USA				
or items 23	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	0. 7				
5-0036 72 hours af natural", or	eted by	3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:  Decedent's Usual Occupation (Give kind of work done during most of work) Ifte. DO NOT use retired)	Specify: white  16b. Kind of Business/Industry				
ZTZT ZTZT d within giene. er than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ashier	grocery store				
land lid be file tental Hy ked othe iic event,	To Be (	17. Father's Name (First, Middle, Last)		: (First, Middle, Maiden Surname) Pilghman				
Maryland 21 nd 2 should be filed w lith and Mental Hygier 27 is marked other ti		19a. Informant's Name/Relationship (Type. Print)  Emil Osterwalder/husband	Mailing Address (Street and Number or Rura 111 Johnson Drive, S	al Route Number, City or Town, State, Zip Code) Salisbury, MD 21804				
<b>SAITIMOTE, IME</b> oermit. Pages 1 and 2  Department of Health a  mportant: If item 27 is any Injury or other trai		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	y, crematory or other place)	20c. Location - City or Town, State  (08 Salisbury, MD				
<b>Baltimo</b> permit. Page Department of Important: If any Injury or	ouce.	a. Synature of Funeral Service Licensee		ome Professional Association Salisbury, MD 21804				
Physicia ≱ /Medic	an	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.	not enter the mode of dying, such as cardiac					
certificate be executed Exiding physician and se as the burial-transit	er ja	Due to (or as a consequence of the control of the c	A very di	ceace				
death certife attending deforuse as	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ⊅⊠No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
	þ	Tall II. Other significant conditions contributing to dead but not resulting in		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes ✓ No 3 ☐ Probably 4 ☐ Unknown				
a a sec	Completed	1		24a. Was an autopsy autopsy performed? 1  Yes 2 No				
VITAL H sician: The certificate I rector, page	Be	25. Was case referred to medical examiner?		(Check only one)				
ing Phys	on:	00 Pet - (Initial Date )		me 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred				
DIVISION OF a or Attending Phy after death.  Director: After this d in by the funeral di	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, fa		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
LIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after deat. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical C							
To th Within To th	Me	29b. Signature and title of certifier	29c. License number					
it.		Afone mg		5-5-28				
int	M	30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)  The S. Division St	- Site 113, Salisbury My 21804				
	State istrar	31. Date filed (Month, Day, Year)  MAY 0 6 2008  32. Registrar's Signature	Section 1	21 904				

		FOI	epartment of Health and It	Mental Hygiene Reg. No. 2 ∩ ∩ Ω								
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death 3. Time of Death								
/Med	ical	Ida M. Price  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	May 2, 2008 8:30 A M								
Exami	ner	10900 Mariner Street	Fort Washington	Prince Georges								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth  April 16, 1917  9. Birthplace (State or Foreign  Virginia								
faryland show ed at	or	Usual Residence of Decedent   10a. State   10b. County   MD   Prince Georges   Fort	Location Washington	10d. Inside City Limits 1 □ Yes ※****  1 □ Yes								
with the A 3a or 28a-f	Director	10e. Street and Number 10900 Mariner Street	10f. Zip Code 20744	10g. Citizen of What Country? U.S.A.								
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes Divorces?  1 Yes, Give Year or Dates:	I3. Was Decedent of Hispanic Origin? (Sj If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black								
Maryland 21215-0036 to 2 should be filed within 72 hours at the and Mental Hygiene. To is marked other than "natural", or traumatic event, the Medical Exami	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work ie. DO NOT use retired) · k	Navy Department								
aryland should be filed and Mental Hyg s marked othe numatic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i> ) Unknown	18. Mother's Nam Nannie	ne (First, Middle, Maiden Surname) Harding								
e, Mary tand 2 shou Health and N tem 27 is man				mber or Rural Route Number, City or Town, State, Zip Code) reet, Fort Washington, MD 20744								
<b>Baltimore</b> , oermit. Pages 1 ar Department of Hea mportant: If Item 2 any injury or other once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)										
Baltimor permit. Pages Department of Important: If It any injury or of		Lincoln Memorial May 7, 2008 Suitland, MD  21. Signature of Funeral Service kicerisee  22. Name and Address of Facility  Lewis Funeral Home  311 N. Patrick St., Alexandria, VA 2231										
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):		or respiratory arrest, Approximate Interval Between Onset and Death								
box 68/60, death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):										
the death certify the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery  Month Day Year								
cords, F.O.  w requires that the d been signed by the should be detached	b	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ► No 3 ☐ Probably 4 ☐ Unknown								
The lar	Completed			24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								
r Si iş	ion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No	tient 3 DOA Other: 4 Nursing He of Vork?	th (Check only one)  ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred								
SIC the the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M   1 □ Yes 2 □ No street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, do not not not not not not not not not no	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated.  rred at the time, date and place, and due to the cause(s)								
To the within 2 To the complete	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
#H		20 Name and address of person who completed arms of death (there can be	D35 Cub	mm 3,2008								
(5)		30. Name and address of person who completed cause of death (Item 23a) (Typ  W.II.m Trankway  17	of Covingston Road	Sout #101 Ft. WASHINGTON, MY								
St Regist	ate rar	31. Date filed (Month, Day, Year)  NAY 0 2008  32. Registrar's Signature										

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or Attending Priysician; The law requires that the death certificate be executed effer death.	leath certificate be execu	Phys /Me Exai	permit. Pages 1 and 2 should Department of Health and Me

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		1 - State Registrar					Ce	ertifica	ate of I	Death	1			No. 4	UÜ	10010
Physicia	an	Decedent's Name					T.CO.T					2. Date of I Month		Day	Year	3. Time of Death
/Medic	al		ERLY	ANN		PELL.	ICOT	1h C	ih. Town or	Location	of Dooth	MAY .	14,2	4c. County	of Dooth	8:50A M
Examin	er	4a. Facility Name (If FREDERI		ORIAL HOS		AL		FI	ity, Town, or REDERI	CK				FREDE		
Funeral		5. Social Security No. 220-42-74		6. Sex 1 ☐ M 2 🔀 F	7. Age		last birthda Yrs.	/) If Un Monti	der 1 Year ns Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Ye.	ar)	9. Birthp Cour	lace (State or Foreign htry)
Director		Usual Residence of		<b>X</b>		63	113.					Nov.	11,	1944	Ма	ryland
yland Iow at		10a. State	10b. County			10c. City	y, Town or l	Location							1	0d. Inside City Limits
a-f sh iffed	ctor	Maryland	Fre	derick	ŀ			4	Jeffei	rson						1 ☐ Yes 2 ☐ No
death with the Maryland ms 23a or 28a-f show I'must be notifled at	Director	10e. Street and Nun	nber					10f.	Zip Code				10g.	Citizen of V	What Cour	ntry?
atn w	ra	4908 Sh	adywoo							1755					5.A.	
er de Items Der m	Funeral	11. Marital Status	O M	12. Was De Armed F	orces?		S. 13	. Was De If Yes, s	cedent of H specify Cuba	ispanic Or an, Mexica	rigin? (Sp ın, Puerto	ecify Yes or I Rican, etc.)	No-		e - Americ k, White,	
urs aft	by F	1 ☐ Never Marri 3 ☐ Widowed	22	If Yes, G	2 N Sive X Dates:	U		1 ☐ Yes	2 No	Specify.	•			Specify	/: W	hite
/2 hou natural lical E)	ted	(5220	15. Decedent	s Education	n		16a. Dec	edent's U	sual Occup	ation	at of ward	-1	16b	. Kind of Bu	usiness/In	dustry
ithin / ie. ian "r	Completed	Elementary/Secon		t grade completed College	(1-4or 5+	-)	life.	DO NO	work done of use retired	during mos f)	st ot work	ang				
riled within Hygiene. Ither than " ent, the Mec		12 Tabbada Nama /		4\				Не	omemak			- (Final Adiaba	//a 44a/a	4 0	Home	
intal F ed of ed ot	Be o	17. Father's Name (		Remsbur	~					18. MOUT		e (First, Midd uise K			<i>'</i>	
z snould be l and Mental is marked c aumatic ev	은	19a. Informant's Na		•	9		19b. Ma	ilina Addr	ess (Street a	and Numb		ral Route Nun				Code)
and z s ealth ar n 27 is ier trau		Robert L.			Husba	and)						fferso.				*
of Hear of Hear filtern rothe		20a. Method of Disp		·		<u> </u>			Name of or other place	ا ۱۵		Date	_	Location -		
rage nent c ant: If any or		1 ☐ Burial 2x 4 ☐ Donation		3 □Removal from ecify)	n State				Cremat		May 20	15, 008	5	Smiths	burg	, Maryland
permit. Fagge 1 and 2 should be filed within 7.2 hours after death with the Marylan permit. Fagge 1 the third man Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service L	icensee		'		22. Name	and Addres	ss of Facili		J.L. 1	Davi	s Fur	neral	Home
			u /ce	Davis		1014				_				ırg, M	<i>[ary]</i>	and 21783
To the			rt failure. List o	complications that only one cause on	each line	9.							arrest,			Approximate Interval Between Onset and Death
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Amortishic lateral sciencesis  Due to (or as consequence of):														
xaminer					J (UI as	consequ	uerice oi).		7							
	ner	Sequentially list cor if any leading to im cause. Enter Under	nving	b. Due to	o (or as a	consequ	uence of):									
eain ceruicate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	injury	C	- /											
ician (		rooming in addition		Due to	o (or as a	consequ	uence of):									
uncate g physi as the l	dic			d												
nding use a	Ž	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, o										23d. Da	te of delive	erv
d for	icia	in the past 12 1 ☐ Yes 2 ☐	months?	4□Preg	birth 2 gnant at t			□Ectopic □Other	pregnancy (specify)	<u></u>				Mo	nth	Day Year
by th	Physician/Medical	9 🗆 Unknown		9□Unk												
been signed by the should be detached	þ	Part II. Other signifi	icant conditio	ns contributing to	death bui	t not resu	ulting in the	underlyin	g cause give	en in Part	I.			-		ne cause of death?  pably 4 Unknown
peen	eted															
sertificate has birector, page 2 s	Completed		<del></del>									24a. Wa au	as an topsy rformed	1 1	Were auto prior to co death?	psy findings available mpletion of cause of
ifficate or, pa		25. Was case referr	red to medical							26 Place	o of Doot	1  Yes	2	No	¹□Yes	21110
yalcı is cer direct	o Be	examiner? 1 ☐ Yes 2 🗹	No	Hospital:	Inpatien	t 2 🔲	ER/Outpati	ent 3	DOA Othe	ar.		ome 5□Re		e 6 □Oth	er (Specif	v)
h. After this c tuneral dire	T :uc	27. Manner of Death	n 5 ☐ Pending	28a. Date (Mo	e of Injury onth, Day	Year)	28b. Time Injury		28c. Injun Work			28d. Describ				
tor: A	catio	2 ☐ Accident 3 ☐ Suicide	investiga 6 ☐ Could n	ation ot be				M		Yes 2 🗌						
after d Direc	Certification:	4 ☐ Homicide	determi	and   286. Plac	ding, etc.	y - At no (Specify	me, farm, s	treet, tac	tory, office			28f. Location City or 7			er or Rura	il Route Number,
within 24 hours after deaft.  To the Funeral Director; A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical E	Physician: To the Examiner: On the and ma	ne best of basis of a	examinat	wledge, deation and/or	ath occurr investigat	ed at the tin	ne, date a pinion, de	nd place, ath occur	and due to the	ne cause e, date	e(s) and ma and place,	anner as s and due to	tated.  o the cause(s)
within To th compl	Me	29b. Signature and		2		A A			29c. License				1	Date signe		* * * * * * * * * * * * * * * * * * * *
			ndeed (	2		וען	D .		DO	064	626	+	1	1ay	14,2	-008
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sandeep Sharma M.D. 400 W. 7th St. Frederick, Md. 21701														
Sta	te.	Sandeer 31. Date filed (Mont			00 W Registra			Free	derick	Md.	217	01			_	
Sta Registr			2 1 20		de .	At.	400	W								

		,	For State Registrar	State of Mai		artment of F rtificate of		, ,	iene <sub>9. No.</sub> 2 () () ()	16619		
	Dhusisi	Prop.	1. Decedent's Name (First, Middle, La	st)		-		2. Date of Death Month	h Day Year	3. Time of Death		
	Physici /Medic		ANNIE	MAY PAL	MER			MAY 1	6 2008	2:00 a.M		
	Examin	er	4a. Facility Name (If not institution, giv				r Location of Death		4c. County of Dea			
			2219 Canada Hill  5. Social Security Number   6.5		(In yrs. last birthday	Myersv		8. Date of Birth	Freder			
3	Funeral Director		217-32-6907	1 M 2 M F	85 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 14,	1922 Ma	rthplace (State or Foreign Jountry) aryland		
	aryland show d at	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	he Ma 28a-f	Director	Maryland Frederi	.ck	Myersv			10	ng. Citizen of What C			
	3a or 2	al Dir	10e. Street and Number 2219 Canada Hill	Road		10f. Zip Code 21773			USA	ountry?		
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh			
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:	, , , , , , , , , , , , , , , , , , , ,		hite		
2-0	72 ho "natur dical I	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deci (Giv	edent's Usual Occup e kind of work done DO NOT use retired	nation during most of work	ding	16b. Kind of Business	s/Industry		
2121	12 should be filed within h and Mental Hygiene. 7 Is marked other than " rraumatic event, the Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	)	emaker	D)	1	Own Home			
p	illed I Hyg other	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	e (First, Middle, N	faiden Surname)			
<u>la</u>	uld be Venta Irked Itlc ev	To B	Roy Milton V	lise			Estell	a Iren	e Jones			
Maryland	2 sho and f Is ma		19a. Informant's Name/Relationship		1				City or Town, State,			
	Health Health tem 27 I		Woodrow Palmer/so	n	20b. Place of Disp				Ile, Mary	land 21773		
Baltimore,	8 5 ± >		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemetery, cre	ematory or other place J.Methodis	ce) ¦		-	e, Maryland		
Balt	permit. Pa Departmer Important: any Injury once.		21. Sign whire of Funeral Se vice Lice	nsee		22. Name and Addre	•		Main Stre rsville, N			
B	H A		23a. Part1. Enter the disease, or con shock or heart failure. List only	plications that caused to	he death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between		
8	Physician		Immediate Cause (Final disease or condition	· C	AV					Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
Ė	L Adminier	<u>-</u>	Sequentially list conditions, b. Due to (or as a consequence of):									
	nsit	nine	Sequentially list containties, if any, leading to immediate cause. Enter Underlying Cause Unleaded or Main's									
Ć,	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):							
68760,	te be ysicia ne bur	edical		_d								
	rtifica ng ph		IF FEMALE:									
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у	<del></del>	23d. Date of do Month	elivery Day Year		
ď.	res that signed by be deta	by Ph	Part II. Other significant conditions	-	not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?		
ords	w require been sig should b	ed b	Alzhei	(1) 5 M				1 □ Ye	es 2∏No 3∏F	Probably 4 Unknown		
or Vital Records,	sician: The law rasice certificate has be irector, page 2 sho	Completed						24a. Was ar autops perform	y prior to ned? death?	autopsy findings available completion of cause of		
ita		BeC	25. Was case referred to medical				26. Place of Dea	1 Yes 2 th (Check only one		5 2 140		
<u> </u>	<u>A</u> .≅ P	10 E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie		4 LI Nursing H	ome 5 Reside	nce 6 Other (Sp	ecify)		
	ing After unel		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wo		28d. Describe ho	w injury occurred			
Sio	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	e 200 Blood of injur	y - At home, farm, s		Yes 2 □ No	28f Location (Str	reet and Number or F	Rural Route Number		
Division	of or Attence after death I Director:	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	rect, lactory, omce		City or Town	, State)	ibrai riotte (vuilbet,		
	To the Hospital or Attend within 24 hours after death. To the Funeral Director; /	edical C		hysiclan: To the best of miner: On the basis of e and manner state	examination and/or i							
	o the	Me	29b. Signature and title of certifier			29c. Licens		29	9d. Date signed (Mor	nth, Day, Year)		
	->-0		)	all lin		DI	6737		5/16/08			
			30. Name and address of person was	completed cause of dea			et. Middl	etown. Ms	aryland 21	769		
*	Sta		31. Date filed (Month, Day, Year)	32 Registrar			,		y = unu	, 5,		
7	Registr	rar	MAIGI	2008	1 St /3							

Colleen Parks	1- For State Registrar	Amerid 1	em 21 pe	r <b>dy</b>	rtment o	Death	29 <b>/0</b> 8	dhb	і пудіє	erie Re	g. <b>N</b> o.	200	8 1662
Physician/ Medical Examine	1. Decedent's Nam	e (First, Middle,Last)	T		n	1			l N	ate of Death lonth ay 4, 200	Day	Year	3. Time of Death 2150 hrs
Medical Examine	00110	if not institution, give s	Joy treet and number)		Pa	arks 4b. City, T	own, or Lo	cation of D		ay 4, 200		County of Death	
	Washington	n County Hospital					rstown			40		ashington	
Funeral Director	5. Social Security 1 214-34-07		7. Age	e (in yrs. la	ast birthday) Yrs	Month	s Days	If Under 2 Hours	Min	Date of Birt		Foreig	thplace (State or in untry)0h1o
á:	Usual Residence of	f Decedent 10b. County		10c. City,	Town or Loca	tion							10d. Inside City Limits
how a	. MD	Washingto	on	На	gersto	vn							1 Yes 2 X No
the Maryland a or 28a-f show any tiffed at once. Director	10e. Street and Nu	ımber				10f. Zip	Code			10	og. Citize	en of What Cou	ntry?
th the N 13a or 10tifie	11920 PI	neasant Tra		_	,		1742					U.S.A.	5
or death with or items 23:	11. Marital Status  1 Never Marri	ied 2 X Married	2. Was Decedent Armed Forces? 1 Yes 2		S. 13. W.	as Decede Yes, specif	nt of Hispa y Cuban, N	nic Originî Mexican, Pi	? ( Specify uerto Rica	Yes or No- in, etc.)	. 1	<ol> <li>Race - Ameri White, etc.</li> </ol>	ican Indian, Black,
ifter de		4 Divorced If	1 Yes 2 Yes, Give Year	A No	1	Yes 2	X No	specify:			s	specify: Wh:	ite
hours aft natural" Examine	15. Decedent's E	ducation (Specify only			16a. Decede during r			n (Give kin		done	16b. Kii	nd of Business/	Industry
5-0036 ed within 72 hour lygiene. ther than "natu the Medical Exan	Elementary/Sec	ondary (0-12)	College (1-4 or	5+)	Teac	her					Ec	ducation	n
5-00 ed will Hygien other	17. Father's Name	(First, Middle, Last)	<del></del>		1000		18	.Mother's I	Name (Fir	st, Middle, N			••
121; d be fill lental H lental H svent, i		rrett Brya			464 44-38					gnes W		n <b>t</b> y or Town, State	7in Codo)
and Me		ame/Relationship (Typ Russo/Dau	•		9.0	-	,				-	Le, MD	21773
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	20a. Method of Dis	sposition	<del></del>		Place of Dispo	sition (Nar	ne of ceme		Da			ocation - City or	
MOT Pages nent of ant: H		X Cremation 3 Other Specify:	Removal from Sta	310	ithsbur	g Cr	emato	ry 5	5/6/2	008	Sm	ithsbur	g, MD
Salti ermit. Departm mports njury (	21. Signature of Fi	uneral Service License										neral C	
Physician	Eric L	he disease, or complic	per of ations that caused	the death	. Do not enter	the mode	of dying, su	LVan1. uch as card	a Ave	piratory arre	est, shoc	stown, ]	Approximate Interval
/Medical	failure. List or Immediate Cause	nly one cause on each	line. Ultiple Injuries										Between Onset and Death
xaminer	or condition result		e to (or as a cons		f):								
à	Sequentially list co	mmediate Du	ie to (or as a cons	equence o	f):								
	cause. Enter Und (Disease or injury	that initiated	ie to (or as a cons	equence o	f)·								
outed nd transit	events resulting in	dd											
60, ate be executed hysician and e burial - transit	UNPENDE	· [	AMENDED										
	IF FEMALE: 23b. Was deceden	t pregnant in the	23c. If yes, outcor	ne of preg		etal death	3	Ectopic p	regnancy			. Date of deliver Month	y Day Year
S f f f f	1 Yes 2	- 9	4 Pregnant at	time of de	- =	other (Spe	cify)						
D. Bc	Part II. Other sign	ificant conditions	9 Unknown  Ontributing to deat	h but not r	esulting in the	underlying	g cause giv	ven in Part	l.	23e. Did to	obacco u	ise contribute to	the cause of death?
P.C.	2									1 Yes	s 2 🗸	No 3 Pro	bably 4 Unknown
Records, The law requires ficate has been significate to the second by										24a. Was autop	osy	prior to	utopsy findings available completion of cause of
Recc The lav					_					perfo 1  Yes	rmed? 2 No	death?	es 2 No
cian:			spital:		1		10	of Death (C			Desides	nce 6 Othe	
of Vi	27 Manner of Des	2 No	ı inpatit		ER/Outpatier 28b. Time of		28c. Injury	7		d. Describe		ry occurred	
OD C ending ath. or: Af	1 Natural	5 Pending	28a. Date of Inju (Month, Day) May 4, 2008	(ear)	2111 hrs		1 Ye	es 2 🗸 N	√o  Dri	ver auto	auto c	ollision	
Division o spital or Attending hours after death. neral Director: After filled in by the fune Certification:	2  Accident 3  Suicide	Investigation  6 Could not be	28e Place of Ir	njury - At h	ome, farm, str	eet, factor	y, office bu	ilding, etc.		or Town, S	State)		ural Route Number, City
% <del>-</del>		determined	(Specify) Ma			<u> </u>	- 41			ute 64, Sm			ted
To the Hospital within 24 hours To the Funeral completely filled	(Check only 1 one) 2	Certifying Physician Medical Examiner:	on the basis of exa	mination a	ige, death occ and/or investig	urred at the ation, in m	e time, date y opinion,	e and prace death occu	e, and due urred at the	e time, date	and plac	ce, and due to t	he cause(s)
P P P P	29b. Signature and		nd manner stated.			29	c. License	number			29d. E	Date signed (Me	onth, Day, Year)
	Call	mi	1/	>	٤		O.C.N	1.E.			May	5, 2008	
5H-5	30. Name and add	iress of person who co	mpleted cause of c ant Medical E			nn Stre	et. Baltir	nore, MI	D 2120	1			
State	04 5 4 51 1 44	ath, Day, Year)	32. Registra		ure	_							
Registra		MAY 0 9 20	USI 💮		A. A.	Lord	L.						

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records. P.O. Box 68760. n 24 hours after death.

In Funcral Director: A pletely filled in by the fu

this certificate has been a director, page 2 should

After the

29b. Signature and title of certifier

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

**8°2**008

Assistant Medical Examiner

2. Registrar's Signature

$\mathbf{\sigma}$							
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ Unknown	23c. If yes, outcome of preg  1 Live birth 4 Pregnant at time of de	2 Fetal death	3 Ectopic pregn		23d. Date of deliver Month	y Day Year
ompleted by PI	Part II. Other significant conditions	contributing to death but not r	resulting in the underlying	g cause given in Part I.	23e. Did tobace  1 Yes 2  24a. Was an autopsy performec  1 Yes 2	No 3 Pro  24b. Were at prior to death?	the cause of death?  bably 4 Unknown  utopsy findings available completion of cause of  'es 2 No
BeC	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ✔		26.Place of Death (Check	only one)	idence 6 Othe	
ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident Investigation	28a. Date of Injury (Month, Day,Year)		28c. Injury at Work?	28d. Describe how		
Sertification:	3 Suicide 6 Could not determined	be 28e. Place of Injury - At h	nome, farm, street, factory	, office building, etc.	28f. Location (Stree or Town, State		ural Route Number, City
dical	29a. Certifier 1 Certifying Physici one) 2 Medical Examiner	ian: To the best of my knowled	dge, death occurred at the and/or investigation, in m	e time, date and place, an y opinion, death occurred	d due to the cause(s) at the time, date and	and manner as sta place, and due to the	ited. he cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State

Registra

29d. Date signed (Month, Day, Year)

April 29, 2008

08-034	432
Derek	Parke

ek Parker		1- Fo	r State	State	e of Maryla	nd / Depa <i>Cer</i>	rtment of <i>tificate of</i>	Health and Death	) Mentai r	тудіепе	Reg. No	2	0.0	8 15	62
Physicia		Regis 1. De	strar ecedent's Name (First,	Middle,L	ast)					2. Date o	Day	Year		ime of Death )437 hrs	
edical Exami	200	D	erek Mau	uric	e Parl	cer			Landing of Dog	May 5	5, 2008	c. County of		7437 1113	$\dashv$
			acility Name (if not ins			nber)		4b. City, Town, or Laurel	Location of Dea	ın .		Prince Ge			
			_aurel Regional F			7. Age (In yrs. la	ast hirthday)	If Under 1 Yea	r If Under 24H	rs. 8. Date	e of Birth(MN	VDD/YYYY)	9. Birthpla	ice (State or	<b>-</b>
Funeral Director			ocial Security Number 77-82-746	_	Sex XM 2 F	37	Yrs	Months Days		lin. 11	/16/		Foreign Country	N.C	
Α.			al Residence of Deced			10c. City.	Town or Local	ion						d. Inside City Lim	. 1
5-0036 led within 72 hours after death with the Maryland sygenc. bygenc. by Hother "natural", or items 23a or 28a-f show any by M-dical Examiner must be notified at once.							attsvi						1	Yes 2	No
yland yland once	ţō		D P	.G.		пу	accsvi	10f. Zip Code			10g. C	itizen of Wha	at Country?	?	
th the Maryla 23a or 28a-f	Director	1	817 Nich	oler	on Stre	et #10	2	2078	3		U	SA			
ith th	a		Marital Status			edent Ever in U	C 13 W	as Decedent of His res, specify Cuba	spanic Origin? (	Specify Ye	s or No-	14. Race - White		Indian, Black,	
ath w items ust be	Funeral	1 [	X Never Married 2	Marı	ied Armed F	orces?	lt.	res, specify Cuba	n, Mexican, Pue	ato Rican, e		Specify: P	•	•	1
Rer de	표	3	Widowed 4	Divor	ced If Yes, Give Yes	ar	1	Yes 2 X No			Laci	Specify:			
ours at atural	Completed by	15	5. Decedent's Educatio	n (Specif	y only highest gra	de completed)	16a. Decede	nt's Usual Occupa	ition (Give kind e. DO NOT use	of work don- retired)	e   160	, Kind of Bus	5111055/11100	isu y	1
5 72 hc ra "nu cal Es	ete	E	Elementary/Secondary	(0-12)	College (	1-4 or 5+)					,,	ariet	-17 et	ore	
5-0036 iled within 7 Hygiene. d other than	E	1	1th	National Action	not)		Stol	ce cler	18.Mother's Na	ame (First, N	vliddle, Maid	en Surname)	)	<u>.010</u>	$\neg \neg$
Ore, MD 21215-0036  18 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiers (if it in 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, he the dical Examiner must be notified at once there are the stream of the stream			Father's Name (First, James Ow	ens	.ast)				Debor	ah Pa	arker				
2121: ould be fil   Mental     marked   ic event,	To Be	19:	a Informant's Name/Re	elationshi	p (Type, Print )			ng Address (Stre	et and Number	or Rural Ro	oute Number	City or Tow			,
and 2 shour fealth and N tem 27 is n traumatic	-	· N	Montess P	. G	ibson(g	-mothe	r 281	7 Nicho	lson S	t.,#	102,	Hyatt	svi]	lle.MD	
_ Pass		20:	a. Method of Dispositio	n		20b	. Place of Dispo crematory or	osition (Name of c	emetery,	Date	120	ic. Location -	- City or To	WII, State	
imore Pages 1 nent of H ant: If i		1	Burial 2 X Cr					. 1 .	5	/9/08	3 R	iverd	lale,	MD	
Baltimore, permit. Pages 1 an Department of Her Important: If ite		21	Donation 5 C	service	icensee		22	Name and Addre	ss of Facility	nera`	l Hom	e Cha	pel.	INC	
Ba Per De Initial	1	1	Donation 5 CO Signature Funer-  a. Lenter the disc	. /4	THUK	#MO117	8 2	120 H S	treet	NE.V	Nashi	ngtor	DC	2000 Approximate Inte	erval
Physician		23	a. Paul Enter the dise	ease, or o	complications that on each ine.	caused the dear	th. Do not ente	r the mode of dyin	g, such as card	ac or respire	atory arrest,	SHOOK, OF THE		Between Onset Death	
<ul> <li>/Medica amine</li> </ul>		Im	mediate Cause (Final	disease	a. Mor hi							_			
amme		or	condition resulting in	death)	Due to (or as	a consequence	of):								
	<b>.</b>	Se if	equentially list condition any, leading to immedi	ns, ate	Due to (or as	a consequence	of):								
	ġ	ca (r	ause. Enter Underlying Disease or injury that in	Cause	C		-6								
-p - <del>-</del>	T vamin	e e	vents resulting in death		Due to (or as	a consequence	or):								
0, be executed sician and	-	<u>-</u>	X UNPENDED		a. AMENDEE	37.00 (	MT2	270 5/23/09	) dah						
O, e be e ysician	i i i	ಜ 🗀	FEMALE:		Loo. 15	z/,28a-I s, outcome of pr	0000001	379 5/23/08	) 11			23d. Date o			
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physon to the Funeral Director: After this certificate has been signed by the attending physon.	as me	Physician/in	b. Was decedent pregrant past 12 months?	nant in th	e 1 Live	e birth	2	Fetal death	3 Ectopic p	regnancy		Month	Da	ay Yea	ır
th cert	asn I	<u>  [</u>	Yes 2 No 9	Link		gnant at time of	death 5	Other (Specify)							
Bo ne dea	or Dan	ا څ	art II. Other significar		9 011	nown	ot resulting in th	ne underlying caus	e given in Part	1. 2	23e. Did toba			he cause of deat	
that if	detached	2	art II. Other significar	it condit	ione continount	,	•				1 Yes	2 No 3	3 Proba	ably 4 🗸 Unkr	nown
S, F quires	B .	Completed								2	24a. Was an autopsy		. Were aut	opsy findings ava empletion of caus	ailable se of
Ord aw re	Sho	흷								— l,	perform  Yes 2	ed?	death? 1 ✓ Yes	. —	
Rec The I	page	5						26 DI	ace of Death (C						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.	completely filled in by the funeral director, page 2 should be	98 <sup>2</sup>	5. Was case referred t examiner?	o medica	Hospital:	Inpatient 2	ER/Outnat	ient 3 🗸 DOA	1011	Nursing Hor		esidence 6	Other		
Physic C.	la dir	0	1 ✓ Yes 2	No			28b. Time		Injury at Work?	28d.	Describe ho	w injury occi	urred		
n of	fune	<u>:</u>  ۲	1 Natural 5	Pen		ate of Injury onth, Day,Yeer) 5/5/2008	End 3	:10 am 1	Yes 2 X	vo ur	known				
SiO Atten death	g H	cati	2 Accident	Inve	stigation 28e. F	lace of Injury - A	At home, farm,	street, factory, offi	ce building, etc.	28f.	Location (St	reet and Nun	mber or Ru	ral Route Number	er, City
Divi	ed ii	21	3 Suicide 6	Cou dete	Id not be Speciermined (Speciermined	<sub>ify)</sub> Jail/	penal in	stitution		Jes	ssup" (CO)	rection	nal Ins	stitution,	, UG
ospita hour unera			Homicide 29a. Certifier 1 Cer	tifyina P			de de e de eth e	sourced at the time	e, date and plac	e, and due	to the cause	(s) and manr	ner as state	ed.	
the H hin 24 the F	plete	ig g	(Check only one) 2 Me	dical Exa	aminer:On the ba	sis of examination	on and/or inves	tigation, in my opi	nion, death occ	urred at the	time, date a	na piaosi			
To T	con	Medical	29b. Signature and title	of certifi	er and mann	cı stateu.		1111	cense number					nth, Day, Year)	
			( a	1	HA.	lla	V	0	.C.M.E.			May 5, 2	800		
(7)		-	30. Name and address	of perso	n who completed	cause of death (	Item 23a)								
5		T)	Carol Allan, M		ssistant Medic	al Examine	r 111 Pe	nn Street, Bal	timore, MD	21201					
	Sta	ate <sup>3</sup>	31. Date filed (Month, I	Day, Year	nne 132	. Registrar's Sig	nature								
		_	M//\Y 2	. 1 /	11171 MIN	RUGA DO		Carlo Carlo							

DHMH 17 Rev 1/2001 OCME 2006

			1 - State Amend Item	State of Ma 2,3,24a pe	ryland r dr	/ Depa • <b>879</b>	rtmen 057	10/08 e of L	ealth a d <b>hb</b> Death	and M	lental Hyg	iené	08	166	23
嘎	01		Decedent's Name (First, Middle, La				1.				2 Date of Dea	th	Year	3. Time of	
٠.	Physicia /Medic		Charles	5	Y:	cke		Tr			May 7,	1		7:30	<b>P</b> M
<u> </u>	Examin	er	4a. Facility Name (If not institution, giv				-	Town, or	Location o	of Death			ty of Death deri		
_	_		College View C	ex 7. Age	e (In vrs. la	st birthday)	If Under		If Under	24 Hrs.	8. Date of Birth				r Foreian
	Funeral Director		217-10-0086	M 2□F 8		Yrs.	Months		Hours	Min.	8. Date of Birth	1920	Cot	place (State of untry)	
-	p ,		Usuel Residence of Decedent  10a. State 10b. County		10a City	Town or Lo	antina							10d. Inside Cit	hy Limite
	Aaryla shov	ō	MD Freder	ick	Too. Oity,		deri	i c k						1 🛣 Yes	
	the M	Director	10e. Street and Number	ICK		LIC	10f. Zip				7	l0g. Citizen o	of What Cou	untry?	
	deeth with the Maryland ms 23e or 28a-f show r must be notified at	iO le	2 James Street	#1E				L701				US	A		
	ems 2	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S	13.	Was Dece	dent of Hi	spanic Ori	gin? (Spo	ecify Yes or No- Rican, etc.)	14. R	ace - Amer	ican Indian,	
0	or the	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ☑AN	10		1 🗆 Yes		Specify:			Spec		ite	
2-003a	72 hours after natural', or ite		15. Decedent's E	Year or Dates:		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of			
0	nin 72 In ne Madic	piet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) Coflege (1-4or 5		(Give	kind of wo DO NOT u	rk done d se retired	<i>luring m</i> os )	t of work	ing			,	
7	e filed within al Hygiene. I other than vent, ILE Ma	Completed	12				Sale	es.				Ret			
yland	be filk d oth	Be	17. Father's Name (First, Middle, Last								(First, Middle,				
E	2 should be and Mental is marked of aumatic ev	٢	Charles S.Pic  19a. Informant's Name/Relationship (		-	10h Mailir	a Addross				Virgin				
<u> </u>	s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Ken Webb	P/R							rederi				
ē,	f Heal f Heal ftem	0.0	20a. Method of Disposition		20b. Pla	ace of Dispo metery, crer	sition (Nar	me of	a)	[	Date	20c. Locatio	n - City or	Fown, State	
Ē	Peges nent of int: If it		1 ABurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special			int 0				5 <b>-</b> 12	2-2008	Frede	erick	k, MD	
Бант	permit. Peges 1 a Depertment of Hes important: If Item any Injury or othe		21. Signature of Funeral Service Lice	/ 4	M011	76 <b>1</b> 0	. Name ar	ast	s of Facilit	y Ke	eney & St. Fr	Basf ederi	ord ck,	P.A. I MD <b>21</b> 7	.H.
d	1		2 a. Part1. Er er the disease, or com shock or heart failure. List only	plications that caused one cause on each lin	the death.									Approximate Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	. St	010	W _								Onset and I	Jeath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									
		Je.	Sequentially list conditions, if any, leading to immediate	b	a conseque	ence of):						-			
	uted d ansit	Examiner	Cause Enter Underlying Cause (Disease or injury that initiated events												
ĵ	an and rial-tra		resulting in death) Last	Due to (or as	a consequ	ence of):									
2/00	certificate be executed ding physician and ise as the burial-transit	Icai		_ d										_	
õ	leath certifical attending phy I for use as th	Med	IF FEMALE:	00- 16	-4										3-10-5-5
DOX	atter for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic p						Date of deli Month		Year
j.	the de by the ached	ysic	1 Yes 2 No 9 Unknown	9☐ Unknown		uiii 3	2001161 (3)	, , , , , , , , , , , , , , , , , , ,							
ر ح	v requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions	contributing to death b	ut not resu	iting in the u	ndertying o	ause give	en in Part I		23e. Did to	bacco use co	ontribute to	the cause of d	eath?
cords,	w require been sig should b	ted t	Covoni	c Res	ral	10	y lu	me			1 🗆 Y	es 2 No	3 □ Pr	obably 4 🗆 l	Jnknown
Š		Completed	Cardra	c our v	YH	nm	1 G.				24a. Was autop	sv	prior to d	topsy findings completion of c	available ause of
<u> </u>	i <b>cian</b> : The lav certificate has rector, page 2	Con									perfor 1 Yes	road? 2X No	death?	2□ No	
VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitaf:				Othe	0.0		h (Check only o				
o	iding Phys th. : After this : funeral dir	: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da		R/Outpatier 28b. Time o		28c. Injun Worl	4 NI	ursing Ho	me 5 Resid			cify)	
VISION	Attending r death. ector: After by the fune	atior	1 Naturaf 5 ☐ Pending 2 ☐ Accident Investigatio		y Year)	Infury	м		k? Yes 2□	No					
<u> </u>	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At hor	me, farm, str	eet, factor	y, office			28f. Location (S City or Tow		mber or Ru	ıral Route Num	ber,
5	itel o rel Di lled in														
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the t	edical	29a. Certifier Certifying Pl (Check only one) 2 Medical Example (Check only one)	nysician: To the best of niner: On the basis of and manner sta	examinati	vledge, deat on and/or in	h occurred vestigation	at the tim , in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the or red at the time, or	cause(s) and date and plac	manner as e, and due	stated. to the cause(s	;)
	To the within 2. To the complet	Me	29b. Signature and the of certifier	und manner ste			29	c. Licensi	e number			29d. Date rig	ned (Monti	h, Day, Year)	
	->-0		> We	= MY			7	>0	06	04	17	5/7	1/2	008	т.
		10	30. Name and address of person who	completed cause of d	eath (item	23а) (Туре,	Print)				-	1	N	15217	2
			Hemen	Shah	16	50	71	non	as	Je	hnsa	1 DV	P	veder	MICIC
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar' Signati	grande	1						•		
	. rogioti		MHI OT FOOD	1											

DHMH 17 Rev 1/2001

16624

3. Time of Death

2:10 a.m

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phy

Division or Vital Records, P.O. Box 68760,

- 7	26140 Barnes Cour	t		Mechanicsville S						St. Mary's			
	Social Security Number     6. Se	ex XIM 2□F	7. Age (In yrs.	**	If Unde Months	er 1 Year Days	If Under 2 Hours	24 Hrs. 8 Min.	8. Date of Birt (Month, Da	:h	9. Bi	rthplace (State or Foreign country)	
	216-28-35/2	A W 2	76	Yrs.					02/24/	1932	2 Ma	ryland	
ŀ			10c. Cit	v. Town or Lo	cation							10d. Inside City Limits	
5												1 ☐Yes 2 XNo	
Sch		S	Mec	hanics	1								
	10e. Street and Number				10f. Zi	ip Code				10g. Citizen of What Country?			
rat													
nue		Armed Fo	orces?	S. 13. \	Was Dece If Yes, sp	edent of F ecify Cub	łispanic Orig an, Mexican,	jin? (Spec , Puerto R	ify Yes or No lican, etc.)	-	14. Race - Am Black, Wh		
Ž		If Yes, Gi	ve		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify:		
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m	Elementary/Secondary (0-12)	College (	1-4or 5+)	_			_	n		Con	ctructi	lon	
ပ္	17. Father's Name (First, Middle, Last)			COLIST	Luc L.	1011			(First, Middle,			LOII	
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-		e	20h F				Court						
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		olications that cone cause on e	caused the deat	n. Do not ent	er the mo	ode of dyi	ng, such as c	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition	a /	neta	SPAC	_	1	ros.	741	C ()	7200	e.6	Onset and Death	
	resulting in death)	Due to	(or as a conseq	uence of):									
	Sequentially list conditions	b											
ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	uence of):									
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Щ	resulting in death) Last	Due to	(or as a consequ	uence of):									
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Medical	IF FEMALE:	d											
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sician/Medical	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 ☐Live I 4 ☐ Pregr	birth 2 ☐ Feta nant at time of d	Ideath 3□	Ectopic		у				23d. Date of de	elivery Day Year	
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	Examiner  10 Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland St. Mary  10e. Street and Number  26140 Barnes Count  11. Marital Status  1 Never Married  2 Marmed  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grave)  Elementary/Secondary (0-12)  7  17. Father's Name (First, Middle, Last)  John Queen  19a. Informant's Name/Relationship (7)  Agnes C. Queen/Wift  20a. Method of Disposition  1 Marital 2 Cremation 3 County  4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen  Kyle S. Simons  23a. Part. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Usual Residence of Decedent  10a. State  10b. County  Maryland St. Mary's  10e. Street and Number  26140 Barnes Court  11. Marital Status  12. Was Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7. Father's Name (First, Middle, Last)  John Queen  19a. Informant's Name/Relationship (Type. Print)  Agnes C. Queen/Wife  20a. Method of Disposition  1 Maurial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Kyle S. Simons  MO1  23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Final disease or injury that initiated events resulting in death)  Due to	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  10e. Street and Number  26140 Barnes Court  11. Marital Status  1 Never Married 2 Mamed  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7  17. Father's Name (First, Middle, Last)  John Queen  19a. Informant's Name/Relationship (Type. Print)  Agnes C. Queen/Wife  20a. Method of Disposition  1 Maryland  1 St. Mary's  12. Was Decedent Ever in U. Armed Forces?  1 Mec.  1 Maryland  1 Never Married 2 Mamed  1 Maryland  1 Never Married 2 Mamed  1 Never Married 2 Maryland  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 1 Never	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  Mechanics  10e. Street and Number  26140 Barnes Court  11. Marital Status  1	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  Mechanicsvill.  10e. Street and Number  26140 Barnes Court  11. Marital Status  1	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  Mechanicsville  10c. Street and Number  26140 Barnes Court  11. Marital Status  1	Usual Residence of Decedent  10a. State  10b. County  Maryland  St. Mary's  Mechanicsville  10f. Zip Code  26140 Barnes Court  11. Marital Status  1	Usual Residence of Decedent  10a. State  10b. County  Maryland St. Mary's  Mechanicsville  10c. Street and Number  26140 Barnes Court  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Formation (Specify Only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Give kind of work done during most of working title. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name  19. Malling Address (Street and Number or Rural 26140 Barnes Court, Mexican, Puerto Formation of the place)  19. Malling Address (Street and Number or Rural 26140 Barnes Court, Mexican, Puerto Formation of the place)  19. Malling Address (Street and Number or Rural 26140 Barnes Court, Mexican, Puerto Formation of the place)  20. Place of Disposition (Name of cometory crematory or other place)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Brital Street and Address of Facility Brital Street Court or Street Court of Street Co	Usual Residence of Decedent   10b. County   10c. City, Town or Location   Maryland   St. Mary's   Mechanicsville   10f. Zip Code   20659   10c. Street and Number   20140   Barnes   20140   Ba	Usual Residence of Decedent   10b. County   10c. City, Town or Location	Usual Residence of Decedent   10b. County	

Registrar

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The process of the pr		Total Control		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest													
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Sequentially list conditions, any lives are not sequence of the conditions of the conditions of the conditions are presented to the cause of the conditions are presented to the cause of the cause of the conditions are presented to the cause of the caus				resulting in death)													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23d. Date of delivery months of the part 12 months?   23d. Date of delivery months of death   23d. Date of lower months of death   23		Examiner															
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25. Was case referred to medical examiner?  1   Yes   2   No   1   Yes	Rec	has ge 2	ld m				·			auto	s an 24b	. Were aut	opsy findings availab ompletion of cause of				
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RICHARD WMM MD 1323 J.M.M. AVANU St. J.M.K. 310 W.M.M. B. D.L. 20032  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	on	ding h. Afte fune	tion	1 ☑ Natural 5 ☐ Pending	(Month, Day	Year)				200. Describe	now injury occu	nea					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Richard Warmer MD 1329 Janharn avenue SE Jank 310 Washing for DE 20032  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		Hospit 24 hours Funera		(Check only 3   Medical E.	(aminer: On the basis of e	xamination	edge, death on and/or inves	ocurred at the tile stigation, in my c	me, date and place opinion, death occu	, and due to the	e cause(s) and n	nanner as:	stated. to the cause(s)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Richard Warmer MD 1329 Janharn avenue SE Jank 310 Washing for DE 20032  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		ithin of the of the of the office of the off	Mec		and manner state	ed.		29c Licens	e number		20d Data sign	od (Month	Day Vaar)				
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		2		Richard Patrier V	4D 1329 Junt	1	sa) (Type, Pri	SE Soute	310 Wa	hingh	in DL	22037	2				
negistral distriction of the state of the st	7	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 200	32. Registrar	s Signature	Could			J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6630PM ROSETTA ROBINSON May 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS COMMUNITY HOSPITAL If Under 1 Year LANHAM PRINCE GEORGE'S 5. Social Security Number Age (In vrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Hours 1 □ M 2 🛛 F 89 Director 223-28-6528 December 6, 1918 Bristol. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 7106 Lois Lane 20703 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No P. 1 ☐ Yes 2 ☐ No à Specify Specify: Black 3 Widowed 4 □ Divorced "natural", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Minister and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DIXON BEIDLEMAN ARTHUR BEIDLEMAN PEARL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 of Health Tennessee 37620 other 1 Carolyn Johnson / Daughter 1404 Sugar Holley Rd. Bristol, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specif VA National Cemetery 5/9/2008 Mt. Home, Tennesse 21. Signature of Funeral Service 22. Name and Address of Facilit Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LIROSEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b ACUTE SMALL BOWEL OBSTRUCTION Examiner NORMAL PRESSURE HYDROCEPHALUS burial-tra Due to (or as a consequence of) nding physician ause as the burial Physician/Medical DIABETES MELLITUS WITH HYPERGLYCINEMIA IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Tes 2 No 3 Probably 4 Unknown CHRONIC RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy page ate 1∐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum\_{\text{Nursing Home}} \) 1 Yes 2 No 1 🔼 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Manner of Death 28a. Date of Injury 28h Time of Certification: 28d. Describe how injury occurred Injury at Work? (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

the death certificate be executed Box 68760. P.0. or Vital Records,

Division

Robin Son, Roset Baltimore, Maryland 21215-0036

Pages .

or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital

Medical

State

31. Date filed (Month, Day, Year, MAY 0 6 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Registrar

MD.

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D62810

29c. License number

29d. Date signed (Month, Day, Year) 05, 2008

MAY

20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May 1, 2008 3:03 A Betty Raudabaugh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year May 5, 1941 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1 □ M 2XX 66 579-88-0343 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√CNo Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2317 Kirby Drive 20748 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2121 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2KKNo Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Legal Transcriptionist Federal Government

18. Mother's Name (First, Middle, Maiden Surname)

Lambert

20c. Location - City or Town, State

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

2008

Clinton, Maryland

29d. Date signed (Month, Day, Year)

Washington DC

Mildred Virginia

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

May 7, 2008

2317 Kirby Drive Temple Hills, Maryland

**Physician** /Medical

**Physician** 

/Medical

Examiner

10a State

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

Gerald P. Raudabaugh / Husband

1XXBurial 2 □ Cremation 3 □ Removal from State

Lawrence

20a. Method of Disposition

Edward

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mason

**Funeral** 

Director

r 28a-f show notifled at show

Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medi al Exeminer must be r

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1

**Examiner** 

Examiner

Be

Medical

State

Registrar

29b. Signature an

Date filed (Month, Day,

MAY 0 6 2008

requires that the death certificate be executed physician and s the burial-trans Physician/Medical use for signed by the a d be detached for Completed by has page 2 certificate I Certification: To this After t To the Hospital or Attending within 24 hours after death To the Funeral Director: filled in by

Division or Vital Records, P.O. Box 68760,

21. Signature of Funeral Service Licer	22. Name and Address of Facility 6160 Oxon Hill Roa		as Funeral Home P.A. rvland 20745
23a. Part1. Enter the disease, or com shock, or heart failure. List only	privations that caused the death. Do not enter the mode of dving, such as ca		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	a Preumonia		Onset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury	b Due to (or as a consequence of):		
that initiated events resulting in death) Last	c		
	»d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions o	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unkno
		24a. Was an autopsy performed' 1 Yes 2	
25. Was case referred to medical examiner?		f Death (Check only one)	
1 Yes 2 No	Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursi	ing Home 5 ☐ Residence	6 ☐Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury at Work?  M	28d. Describe how in	jury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	ussician: To the best of my knowledge, death occurred at the time, date and niner: On the basis of examination and/or investigation, in my opinion, death and manner stated.		

132 & Jowhen avenue

32. Registrar's Signature

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

22. Name and Address of Facility

29c. License number

D0085120

310

For WCHD/SH 5/12/08 State of Maryland / Department of Health and Mental Hygiene Certificate of Coath Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death. 2. Date of Death 4000 1. Decedent's Name (First, Middle, Last) Day Year 5:30 PM **Physician** 5 2008 Peter E. Rafferty /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown Washington Washington Co. Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 30, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Days Hours M 2□F 85 1922 146-16-9867 New Jersey Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Hagerstown Washington Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21742 USA 246 Potomac Heights 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ▼IXY'es 2□No 1Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify: Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Parcel Warehouse Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Menta item 27 Is marked Elizabeth Doyle P William Rafferty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

246 Potomac Heights, Hagaerstown, MD 21742 19a. Informant's Name/Relationship (Type. Print) Patricia Rafferty O'Dell(SIster) 20b. Place of Disposition (Name of cemetery, crematory or other place) May 10, 2008 Totowa, New Jersey permit. Pages 1 Department of H Important: If ite any Injury or ot 1 N Burial 2 Cremation 3 Removal from State Holy Sepulchre Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc. Signature of Funeral Service Licensee M - 0084948 S. Church Street, Waynesboro, PA 17268 Part1. Enter the disease, or complications that caused shock, or heart fallure. List only one cause on each light Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** GYOMAN /Medical Due to (or as a consequency of): Examiner Due to (or as a con uence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Linpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 april Court, Hageistown seem, mo -5+ nammad 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician**  $May^{Month}7,2008$ Norma Joyce Ann Dxon Ritchie 6:45pm м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Year)
Dec. 1, 1935 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 578-46-1490 1 ☐ M 2 🗙 F 72 Kankokee, Il. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Mitchellville Prince George's 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 3800 Lottsford Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Banking Customer Service Rep. 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked otheny or other traumatic event 17. Father's Name (First, Middle, Last) Be Harold Brice Dixon Regina Leona Wynkoski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Ray Cranford/Daughter 3400 Lancer Ct. Dunkirk,MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem Brentwood, MD 2008 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are completely shock, or heart failure. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -5 /Medical Due tour as a consequence of) Examiner Sequentially list conditions, if any, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diseito (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → Nk ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitai or Attending Natural Iniury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)
MAY 0 8 2008 Registrar

29b. Signat

and title of certifie

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

MO

29c. License number

29d. Date signed (Month, Day, Year)

08-03522
Jeffrey Reynolds

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marviand / Department of Health and Mental Hygiene

Jenrey Neyriolds		For State of Maryland / Department of Health and Mental Hy Certificate of Death Registrar		Reg. No.	200	8 16631
Physiciar	1	1. Decedent's Name (First, Middle,Last)	2. Date of Dea		Year	3. Time of Death
Medical Examin		JEFFREY REYNOLDS  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	May 8, 20	008	. County of Death	1020 hrs
		10505A 46th Avenue Apt. 202  Beltsville			Prince George	
Funeral Director		524-84-7246 1 XM 2 F 50 Yrs. Months Days Hours Min.	_		/DD/YYYY) 9. Bir Foreig Co	thplace (State or 90 GERMANY untry)
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
ind show	۱,	MD PRINCE GEORGES BELTSVILLE				1 X Yes 2 No
Maryla	Director	10e. Street and Number 10f. Zip Code		10g. Citi	izen of What Cou	ntry?
with the Mary!  so 23a or 28a-f  be notified at o		10405 A 46TH AVENUE APT. #202 20705	anifu Von an N		SA Sees Amer	ican Indian, Black,
eath w	runeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? X No 13. Was Decedent of Hispanic Origin? (Sp. 15. Married Forces? X No 15. Married Forces? X No 16. Married Forces? X No 17. Married Forces? X No 17. Married Forces? X No 18. Married Forces? X No 18. Married Forces? X No 19. Married Forces Forc		0-	White, etc.	icari indian, black,
after d	<u> </u>	3 Widowed 4 Divorced If yes, Give Year or Dates:			Specify: WH	ITE
hours natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		16b.	Kind of Business/	Industry
36 thin 72 than than edical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4 YEARS CARPENTER		P	RIVATE	
MD 21215-0036 at 2 should be filed within 7 tith and Merkel Hygiene. m 27 is marked other than anantic event, the Medica		17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle,			
121 Id be fi Mental narked event,	90	JOHN REYNOLDS  JANE LA  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Fig. 1)		ımber C	ity or Town State	a Zin Code)
AD 2 shouth and D 27 is numatic	-	JAMES REYNOLDS/BROTHER 7160 ANNAPOLIS WOODS				
re,		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		Location - City or	
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: RIVERDALE CREMATORY 05/	14/2008	RI	VERDALE,	MD
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumate event, the Medical Examiner must be notified at once.		21. Situal r of Funeral Service Licensee 22. Name and Address of Facility J. 7474 LANDOVER ROAD	B. JENK LANDOV	INS ER,	FUNERAL MD 2078	HOME 5
Physician /Medical	1	23a. Part I. Enter the di. aa e, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
¬wedical		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease  Due to (or as a consequence of):				Death
		Sequentially list conditions,  b	<u> </u>			
		if any, leading to immediate Due to (or as a consequence of):				
red	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Ilospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED #23a,27,perME,g879 5/23/08 TT				
8760, ificate be ng physic sthe bur	Σ [	23b. Was decedent pregnant in the	ancv	23	3d. Date of deliver Month	y Day Year
Box 687 e death certific the attending p	Sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
the dear by the a	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e, Did	tobacco	use contribute to	the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the ra after death.  "al Director: After this certificate has been signed by the funeral director, page 2 should be deach director, and the funeral director of the deach director and the funeral director and the f	a		1 🗌 Y	es 2	No 3 Pro	obably 4 🗹 Unknown
rds,	Completed		24a. Wa	s an opsy		utopsy findings available completion of cause of
Reco	e			formed?	death?	
tal F	a Re	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing				
Physical this and direction	의	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Outsite Nursin	ng Home 5		lence 6 🗹 Othe	er: Scene
		1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			,,	
ViSicor Atte	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,		and Number or R	ural Route Number, City
Di spital hours a neral I	5 -	4 Homicide (Specify)  29a. Certifier Cartistics Physicians Table holds for substantial debt population debt population and size of the specific physicians and spe				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
FEF8	ğ	29b. Signature and title of certifier 29c. License number			. Date signed (M	onth, Day, Year)
		Carol Hallan O.C.M.E.		Ma	ay 9, 2008 	
0	ſ	<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120</li> </ol>	01			
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature 2				
Registr		MAY 1 4 2008 Proceed 15				

	I- For State Registrar	ate of Maryland	/ Departme <i>Certifica</i>			and Ment		R	leg, No.	201	12 166	
Physician/ ledical Examiner	1. Decedent's Name (First, Middl Patricia		spess				I -	. Date of Dea Month May 9, 20	Day 008	Year	3. Time of Death	
į.	4a. Facility Name (if not institutio Peninsula Regional M	-	)	4b	. City, Town, Salisbury	or Location of	f Death			ounty of Death Comico		
Funeral Director	5. Social Security Number 027–40–5948	6. Sex 7. Ag	e (In yrs. last birt	hday) Yrs.	If Under 1 \ Months	ear If Under	Min.		/1951	Co	thplace (State or Foreign untry) ssachusetts	
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n						10d. Inside City Limits	
land f show		omico	Sa.	Lisbu							1 XYes 2 No	
the Maryland a or 28a-f sh officed at once	10e. Street and Number 1009 E. Schum	aker Manor D	rive		10f. Zip Code 10g. Citizen of What Country?  21804 USA						ntry?	
er death with the Maryland , or items 23a or 28a-f show r must be notified at once. Funeral Director	11. Marital Status  1 Never Married 2 X M	arried 12. Was Decedent Armed Forces 1 Yes 2				Hispanic Orig ban, Mexican,			0- 14	I. Race - Amer White, etc.	American Indian, Black, etc.	
urs after unural", o	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Year or Dates:	mpleted) 16a.	Decedent's	s Usual Occu	No specify: pation (Give k		Specify: white work done 16b. Kind of Business/Industry				
136 thin 72 hour te. than "natu edical Exan	Elementary/Secondary (0-12)	College (1-4 or	5+)	Ü		ife. DO NOT ental a			đến	ntistry		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Father's Name (First, Middle					18.Mother	s Name (	First, Middle,	Maiden Su	ırname)		
2121 ould be fi d Mental I s marked tic event,	Charles Geof		19	b. Mailing	Address (S			ine Pl ural Route Nu		or Town, Stat	e, Zip Code)	
MD d 2 sho Ith and in 27 is	James W. Resp	ess/husband	1				r Ma				y, MD 21804	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other S		tate cremat	tory or other	ion (Name of er place) Crema	The state of the s	5/13	Date 3/08	ł	cation - City o		
Balti permit. Departm Imports injury o	21. Signature of Funeral Service		SIP	22 No	me and Add	ross of Facility	,				Association 804	
Physician /Medical xaminer	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	on each line.		ot enter the	e mode of dy	ing, such as ca	ardiac or	respiratory a	rrest, shock	k, or heart	Approximate Interval Between Onset and Death	
rsit Examiner	Sequentially list conditions, if any, leading to immediate eause. Enter Undarrying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons										
60, e be executed ysician and burial - transit	X UNPENDED	d AMENDED 23a 27 28;	of move	~00n 4		<del>лп</del>						
Box 68760 he death certificate by the attending physished for use as the bubysical Physician/Me	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?  1 Yes 2 V No 9 Un	he 23c. if yes, outco	ome of pregnancy	2 Fet	al death er (Specify)		c pregnar	ncy		Date of delive	ry Day Year	
P.O. Be so that the de e detached f by Phy	Part II. Other significant condi		th but not resulting	ng in the u	nderlying cau	ise given in Pa	art I.				o the cause of death?	
sion of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the cation: To Be Completed by Physician/IM	<u> </u>		· · · · · · · · · · · · · · · · · · ·					per	is an opsy formed?	prior to death?		
tal F	25. Was case referred to medica examiner?	Hospital:				Place of Death Other			7		······································	
n of Vi ting Physi After this funeral dir	1 Yes 2 No  27. Manner of Death  1 Natural 5 Death	28a. Date of In (Month, Day)	jury Year) 28b.	Outpatient Time of Ir	jury 28c.	Injury at Worl	</td <td>g Home 5</td> <td>Residen</td> <td></td> <td>er:</td>	g Home 5	Residen		er:	
	2 Accident Inve	stigation 5/6/2008 ld not be 28e. Place of I	Injury - At home, f			Yes 2 X		28f. Location or Town	n (Street an . State)		ural Route Number, Cit	
C Trie by	29a. Certifier 1 Certifying F	hysician: To the best of raminer: On the basis of ex						due to the ca	use(s) and	l manner as st		
To the He within 24 To the Fu complete!	29b. Signature and title of certific	and manner stated		3	29c. Li	cense number			29d. D		fonth, Day, Year)	
	Name and address of person Laron Locke MD.	n who completed cause of Assistant Medical Ex			Street, B	altimore, N	1D 212	01				
State	31. Date filed (Month, Day, Year,	32. Registr	rar's Signature									
Registrar	MAY 1	1 2008	and the	RIGINA	all I						- 1	

OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** MAY Ring 02 2008 Lee Richard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SALISBURY Nicomico MEDICAL (ENTER EGIENAL ENINSULA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 220-26-7780 Director 76 10-3-1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2X No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1365 Pemberton Drive 21801 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2□No 1948 1 ☐ Yes 2X No Specify Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 1952 other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Utility Company Relay Tester 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Evelyn Webb ဥ Ring 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. 1365 Pemberton Drive, Salisbury, MD 21801 Susan Ring - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Wicomico Memorial Pk. 5-6-08 |Salisbury, Maryland 22. Name and Address of Facility 21. Sonature of Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 my 1ews **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 □ Yes 2 □ No performe 2 - NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, has been signed 2 should b certificate ha this After t

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Mental

Baltimore, Maryland 21215-0036

Certification: To

Medical

29a. Certifier (Check only one)

29b. Signature and

Director: , within 24 hours at To the Funeral C completely filled i

MARRON State

6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29d. Date signed (Month, Day, Year)

- 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

			For State Registrar	State of Maryland		tment of He ificate of L			jiene leg. No. 🥎	000	10000
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) PAMELA L.	SMITH				2. Date of Dea Month APRIL	Day 30	Ž008	3. Time of Death 9:43 PM
)	Examir	- 4	4a. Facility Name (If not institution, give str HOLY CROSS	HOSPITAL			ER SPR	ING	MC	unty of Death DNTGOM	
	Funeral Director		3/3 /0 4443	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day DEC 4	195	9. Birthpl Count 1 WASH	ace (State or Foreign
	Maryland -f show ied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD •         MONTGOM		own or Loca	R SPRIN	īG			10	od. Inside City Limits  Y Yes 2 □ No
	a or 28a st be notif	al Director	10e. Street and Number 2958 HEWITT AVEN	NUE #312		10f. Zip Code 2 0 9	906		10g. Citizen	of What Count	try?
36	rs after deat I", or Items 2 kaminer mu	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:		as Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - America Black, White, e	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may Injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. Di	ent's Usual Occupa ind of work done do NOT use retired, L SECRE	luring most of wo )	rking	16b. Kind	of Business/Ind	
	ild be filed w lental Hygie ked other ti ic event, th	To Be Co	17. Father's Name (First, Middle, Last) VIRGIL WILLIA	AMS			18. Mother's Na	me (First, Middle, A BAUM			
, Maryland	is 1 and 2 shou of Health and M item 27 is mar other traumat		19a. Informant's Name/Relationship (Type CHERITA D. SMITH		-	Address (Street a			-		
Baltimore,	t. Pages 1 at the trant: If item ijury or other		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State PARK	LAWN	ition (Name of atory or other place MEM • PA	ARK 5/	Date 9/08	ROCK	tion - City or To	wn, State , MD. . 20010
Ba	permir Depar Impor any Ir		21. Signalus of Funeral Service Licensee	7	W		. н. 34			, N.W	WASH DC
	Physician /Medical Examiner	er	23a. Part1 Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying	cause on each line.  CEREBRAL H  Due to (or as a conseque)  CEREBRAL M	EMORI nce of): ETAS	RHAGE	g, such as cardia	ico i respiratory ar	reat,		Interval Between Onset and Death
68760,	icate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequen							
.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	ic. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗌	Ectopic pregnancy Other <i>(specify)</i>			230	d. Date of delive Month	ery Day Year
Д.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cont	tributing to death but not resulti	ng in the un	derlying cause give	en in Part I.				ne cause of death? pably 4X]Unknown
or Vital Records,	(0 12	Completed						24a. Was autop perfo 1∐ Yes	rmed?	prior to con death?	psy findings available mpletion of cause of 2 ☐ No
Vita	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐XNo	ospital: 1 [ <b>X</b> !npatient 2 □ E	3/Ottit	Othe	35.	eath (Check only o		Jon 10 11	
0	g Physer this eral di	n: To	27. Manner of Death	Tampatient 2 Er	8b. Time of Injury	28c. Injun		Home 5 Resident Resid			y)
Division	r Attending er death. rector; After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At hom building, etc. (Specify)		M 1 🗆	Yes 2 No	28f. Location (S		Number or Rura	al Route Number,
۵	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		(Check only 2 Medical Examin	ician: To the best of my knowler: On the basis of examination							
<b>\</b>	To the within 2 To the complet	Medical	29b. Signature and title of certifier  Manley a	Schwork	NS	29c. License	9 number 7368		29d. Date :	signed (Month,	
	(3)		30. Name and address of person who cor	mpleted cause of death (Item 2	3a) (Type, F	Print)				209	
	y € Sta	to.	STANLEY A. SCHWA	ARTZ M.D. 21  32. Registrar's Signatu		EDICAL ]	PARK DI	R. SILV	ER SI	PRING,	MD
	31	T.C	MAY O E 2009	W de	16.0						

DHMH 17 Rev 1/2001

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $3^{\mathsf{Day}}$ Month Physician Мау JUAN STRAUGHTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Magnolia Center
5. Social Security Number 6. Sec Lanham
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington DC 7. Age (In yrs. last birthday) Funeral<sup>1</sup> 11 M 2□F Months 37 Yrs 578 11 9313 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other then "natural", or items 23a or 28a-f show other treumetic event, the Medical Experiment has been the most be notified at Directo Prince George Oxon Hill Md10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20745 714 Quade Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status within 72 hours after + Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wn Department of Health and Menial Hygien Important: If Item 27 is marked other the eny injury or other treumetic event, II.s. once. Private Security  $12 \pm h$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Denise Johnson ပ္ George Straughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise S. Bray, Mother 714 Quade Street, Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/10/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 21. Signat ure of Funeral Service Licensee 621 Florida Avenue, NW, Washington Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. shock, of heart fail Immediate Cause (Final Human Immunodeficiency Virus AIDS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine burial-transit Bud resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 5 in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð Completed

Hospital: 1 ☐ Inpatient

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Approximate Interval Between Onset and Death Years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) May 4,2008 4203 QueenburyRd Hyattsville, Maryland

3. Time of Death

10d. Inside City Limits

U.S.A

1 Yes 2 No

8:40 pM

200 8

Division of Vital the Hospital or Attending Physician: npletely filled in by the funeral after death within 24 hours a

certificate

death

Be

ဥ

Certification:

Medical

25. Was case referred to medical examiner?

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAY 0 6 2008

5 Pending investigation

6 Could not be determined

A. DeVore MD

1 ☐ Yes 2 🙀 No

27. Manner of Death

1 ⊠Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

State Registrar 2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3 DOA

28c. Injury at Work?

29c. License number

D01852

1 ☐ Yes 2 ☐ No

			For State Registrar	State of Marylar		artment of F ertificate of		Mental Hy	giene Reg. No.	2000	1 ccol
	1.16		Negistrar     Name (First, Middle, Last)			Timouto o.	204.17	2. Date of De	eath	2 U U B	3. Time of Death
	Physici /Medic	_	LEROY SM	ITH				MAY	01,	2008	11:11 A M
	Examir	er	4a. Facility Name (If not institution, give st		mnp.		r Location of Dea	th		COUNTY OF Death	EORGE'S
21,32	Funeral		SOUTHERN MARYLAND  5. Social Security Number 6. Sex	7. Age (In yrs		CLINT  of If Under 1 Year	If Under 24 Hrs		rth		lace (State or Foreign
	Director		578-68-6756	M 2□F 57	Yrs.	Months Days	Hours Min	. (Month, Di 10/5/1			ington,DC
pue	we ti		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or L	ocation				1	0d. Inside City Limits
Mary	a-f sh ified a	tor	Maryland Prince Geo	roe's Te	mple I	H111s					MXYes 2 □ No
ith th	or 28 se not	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Coun	itry?
eath w	is 23a must l	Funeral	2011 Chadwick Terra	.ce 2. Was Decedent Ever in U	15 13		20748			d State: 4. Race - Americ	
<b>036</b> urs after d	al", or item xaminer	ρ	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	7.3.	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:	rto Rican, etc.)		Black, White,	etc.
d 21215-0036 filed within 72 hours after death with the Marvland	ntal Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Exa <u>miner must be notified at</u>	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dec (Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of wo d)	orking	16b. Kind	d of Business/Ind	dustry
22   ed   w	Hygier ther the	Cor	17. Father's Name (First, Middle, Last)		Lab	orer	18 Mother's Na	me (First, Middle		vate	
Maryland	e d c	To Be	Connell Smith					ie Lott	, maiden o	uname	
ary shou	and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Type	e. Print)	19b. Mai	ling Address (Street			ber, City or	Town, State, Zip	Code)
	of Health and Meritem 27 is marke other traumatic	. 9	Tonga Peterson / St	ster	4213	Steeds G	rant Way	Ft. Was	hingt	on, Mar	yland 20744 own, State
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Baltimore, permit. Pages 1 ar	Department of important: If it any Injury or o		21. Signature of Funeral Service License	, , , , ,		22. Name and Addre			l	•	-
m a	P E E		Kath a. A	enge 40108	_	538 Marlb				Mary1a	nd 20747
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x 68 ertifica	ling ph e as th	Med	IF FEMALE:								
BOX leath cer	aftending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	☐Ectopic pregnanc	у		23	3d. Date of delive Month	ery Day Year
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VITal Records, P.O. Box 68760, sician; The law requires that the death certificate be executed	been signed by the s should be detached t	þ	Part II. Other significant conditions cont	ributing to death but not re-	sulting in the	underlying cause giv	ven in Part I.			e contribute to th No3 ☐ Prob	ne cause of death? pably 4 Unknown
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<u>명</u> 를	certificate has birector, page 2 s		OF Miss and referred to medical						ormed? 2 <b>2</b> No	death? 1 ☐ Yes	2₩ No
Vslcla	s certi	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	espital: 1 Inpatient 2 □	] ER/Outpatie	ent 3 DOA Oth	ner	eath <i>(Check only</i> Home 5 ☐ Res		□Other (Specif	(v)
n Or	fter th		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju		28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISION I or Attending	death.	icatio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At h	omo farm e		Yes 2 □ No	29f Location	(Stroot and	Number or Rum	al Route Number,
בי פֿן	after (	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	ireer, ractory, cinice			wn, State)	Number of Hure	ar noate ivainbei,
ne Hospita	within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C		cian: To the best of my kn er: On the basis of examin and manner stated.							
Tot	To tl	Me	29b Signature and title of certifier			29c. Licens		,	29d. Date	signed (Month,	Day, Year)
							6374		5	12/01	
_			30. Name and address of person who cold	pleted cause of death (Ite	m 23a) (Type	Print) Hem	Ave)E	Washin	ngfm	DC 20	0032
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	ature						

Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 05 SHIRLEY SQUIRES 08 13 2202 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Davs Hours Feb 10, 1936 MD 214-34-2178 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medica Examiner must be notified at 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13406 Uhl Highway SE 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/manager Gardener's Candy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lester W. Harvev Ramona May Harvey Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13406 Uhl Highway SE Cumberland MD 21502 J. Richard Squires husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/16/2008 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Lice 108 Virginia Avenue: Cumberland, MD 21502 23a Part1 Enter the dise se, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediale Cause (Final disease or condition resulting in death) Physician MYUCARDIAL hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy performed OBESIT 2**2** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1/X/Natural 5 Pending investigation 1 Yes 2 No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) Registrar's Signature MAY 21

ivengood mD

and manner stated.

29b. Signature and title of certifle

1aylor

30. Name and address of person who completed caus

of death (Item 23a) (Type, Print)

912

29c. License number

Seton Drive Cumberland Md. 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:35 AM George Sylvester Scott Snyder  $\mathcal{M}$ a 16,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Center for Rehabilitation Cumberland Allegany 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Months Days Hours Min. May 31, МD Director 217-10-5041 92 1915 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Allegany Cumberland 1.∏Yes 2∏No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 416 N. Mechanic Street 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Armed Forces?

1★Yes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio Specify: Specify: 3X Widowed 4 ☐ Divorced white other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Laborer Celanese 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles F. Snyder Elmyra S. (Martz) Snyder ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Jane Trai: daughter 416 N. Mechanic Street Cumberland 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/2008 Rocky Gap Veterans Cemetery MD Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Page Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease or condition and the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 4vs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events: resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No or Attending Physician; director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient funeral 27. Manner of Death 1 □ Natural 2 □ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation the after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar

29b. Signature and title of certified

1m 31. Date filed (Month, Day, Year)

30. Name and address of person who con letted cause of death (Item 23a) (Type, Print)

) (025 Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-003

Division or Vital Records, P.O. Box 68760,

10033280

Kent Avenue, Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Edith Virginia SEIBERT 12:35 p.M May 7, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood Nursing Home Williamsport Washington Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea April 4, Year) 1 □ M 2 🗓 F 79 217-32-5258 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Washington Williamsport 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 16213 Natural Well Road 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: 3 XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Perry Beckley Mary Pearl Harsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8218 Fair Isle Terrace, Chesterfield, VA. 23838 David G. Seibert, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem Reformed Cem. 5/12/08 Hagerstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Ye ar 4 Pregnant at time of death 5 Other (specify)

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

28a-f show

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23a

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"natural"

It of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, Item Item

permit. Page Department of Important: If any Injury or once.

Examiner must be notified

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical ₹ Completed Be Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Lamber Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital within 24 hours a To the Funeral C completely filled

Division of Vital Records, P.O. Box 68760,

9 Unknown	9 ☐ Unknown				
Part II. Other significant conditions conditions	ntributing to death but not res	ulting in the underlying	cause given in Part I.		se contribute to the cause of death?  ¶No 3 Probably 4 Unknown
Africa tisfiller	Non Kroff			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
25. Was case referred to medical examiner?	7-1		26. Place of De	eath (Check only one)	
1 Yes 2 No	lospital: 1   Inpatient 2	ER/Outpatient 3 □	DOA Other: Nursing	Home 5 ☐ Residence 6	Other (Specify)
27. Manner of Death  1 Natural 2 Accident  5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	sician: To the best of my kno ner: On the basis of examina				and manner as stated. place, and due to the cause(s)

D26806 Mas 8, 2008 Neue Haggitan MO21742

State Registrar

Medical

29b. Signature and ti

and manner stated.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Cer	tificate of	Death		Reg. No.	2000	
П	Physicia		Decedent's Name (First, Middle, La      TANTE C.		CM.	TOTI		2. Date of De Month MAY	Day	2008 Year	3. Time of Death - 5:13PM
(4) (4)	/Medic	al	JAMES  4a. Facility Name (If not institution, giv	C.	SM.	Ah City Town	or Location of Death	PIA.1		County of Deat	
	Examin	er	LAUREL REGIONA			LAU					EORGE'S
1 90	Funeral Director		233-88-6080	Sex 7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da JAN 16	th ay, Year) 1955	I Co	hplace (State or Foreign buntry) I VIRGINIA
	Maryland -f show ied at		Usual Residence of Decedent  10a. State 10b. County  MD PRINCE		, Town or Lo	cation					10d. Inside City Limits 1 X Yes 2 ☐ No
	with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 8300 IMPERIAL DR	IVE		10f. Zip Code 20708			10g. Citize	en of What Co A	ountry?
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces?  1 X Yes 2 D No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 XNo	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: B	
21215-0036	iin 72 hou Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	ing		d of Business	/Industry
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Maryland	ld be filed lental Hygis ked other ic event, t	Be	17. Father's Name (First, Middle, Last UNKNOWN	")			18. Mother's Nam	e (First, Middle SMIT		Surname)	
ž	2 should be and Menta is marked aumatic ev	은	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Stree	t and Number or Ru	ral Route Numb	ber, City or	Town, State,	Zip Code)
Z	nd 2 s lith an 27 is r trau		KAREN SMITH/WI				L DRIVE L				
Baltimore,	0 0	18	20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3 \( \)  4 \( \) Donation 5 \( \) Other (Special Content of the c	Removal from State	Place of Disponentery, created SQUIRE	osition (Name of matory or other pl CEMETER	ace) Y 5/10	Date / 2008	20c. Loc HINT	oation - City or	Town, State ST VIRGINIA
Baltii	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Lice				ress of Facility J				
		П	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deat	h. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a ESOPHOGEAL							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		- 5					
	Examine	<u>.</u>	Sequentially list conditions,	b. HYPERTENSI							
	nsit	Examiner	Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	HEPATIC CI		[S					
60,	rificate be executed g physician and as the buriat-transit		resulting in death) Last	Due to (or as a conseq							
68760,	tificate ig physi as the	Medical		d					- 1		
.O. Box	death ce e attendir d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3	⊒Ectopic pregnar ⊒ Other (specify)			2	3d. Date of de Month	elivery Day Year
Δ.	juires that t signed by Ild be detac	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	underlying cause o	jiven in Part I.		tobacco u		to the cause of death?  Probably 4 □Unknown
Records,	The law requires that the rate has been signed by the page 2 should be detached.	Completed		<u> </u>			-	24a. Wa aut per 1 Yes	opsy formed?	prior to death?	autopsy findings available completion of cause of s
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th Check onl	one		
ō	Phys r this ral dir	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time ( Injury	HIL S DOA		lome 5 Re			ecify)
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	1 XNatural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of injury - At h	ome, farm, st	M 1	☐Yes 2☐No	28f. Location City or T	(Street and	d Number or F )	Rural Route Number,
Q	ospital o hours af uneral D ly filled ir		29a. Certifier 1 🛣 Certifying F	Physician: To the best of my known aminer: On the basis of examination	owledge, dea	th occurred at the	time, date and place	e, and due to thurred at the tim	ne cause(s)	and manner a	as stated. ue to the cause(s)
	the H nin 24 the Fi	Medical	one)	and manner stated.			nse number				nth, Day, Year)
<b>\</b>	With Con	2	29b. Signature and title of certifier	I Legonic	•		52865			-	rd 2008
R	(10)		30. Name and address of person wh	o completed cause of death (Itel	m 23a) (Type	Print)	OSIS DRIV	E BOWTI		-	
1	SI SI	ate	31. Date filed (Month, Day, Year)	a 32. Registrar's Sign		TOTO LIVE	TODIO DILI		_,		
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DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ann M. Shibley May 5, 2008 4:53 $P^{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bowie Health Center Prince George's Bowie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Dec. | 9 , 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 61 1946 214-46-3211 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Prince George's Lanham 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 5514 Duchaine Dr. 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry Prince George's Co. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Findlay Dorothy Willison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Shibley / Spouse 5514 Duchaine Dr. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Nat'l Mem. Park 4 □ Donation 5 □ Other (Specify) 5/9/2008 Laurel, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home Her 6512 NW Crain Hwy. Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final erebrorgswar disease or condition resulting in death) 5 MINUTES Due to (or as a consequence of) pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 'SK No 1 🔲 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 Yes 2 No

**Physician** /Medical Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

MD

Director

Funeral

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Completed

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attending physician and for use as the burial-tran ed by the a has this c within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral.

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Completed

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Certification:

Medical

Registrar

State

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

se of death (Item 23a) (Type, Print)

Brandemill Blvd. Ste 200 Gambrils 31. Date filed (Month, Day, Year)

MAY 0 8 2008



28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

08-03637

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Samuel Joseph S	1	- For State	ate of N	Maryland / D	eparl <i>Certi</i>	tment of ficate of	f Healtl f <i>Death</i>	n and Ment	tal Hyg		g. No. 2	0.0	8 1664
Physicia	n/	teqistrar 1. Decedent's Name (First, Midd		1. (	· · · · · ·	ana T	тт			Date of Death Month	Day Yea	r	3. Time of Death 1418 hrs
Medical Examir درکم		Samuel  4a. Facility Name (if not institution	Jose	•	summe	ers, I		own, or Location of		May 12, 20	4c. County of	of Death	
d .		9707 Croom Road	o., g	,			Upper	Marlboro			Prince G	_	
Funeral Director		5. Social Security Number	6. Sex			t birthday) Yrs	If Unde Months		_	8. Date of Birt		Foreig	hplace (State or in <sup>untry)</sup> Maryland
	ŀ	212-29-8136 Usual Residence of Decedent	I	2 F 2:			*			09/10/	1900		
v any		10a. State 10b. County		10	c. City, T	own or Loca	tion						10d. Inside City Limits  1 Yes 2 X No
land f shov	ē	Maryland Princ	e Geo	rge's	Bra	<u>andywi</u>	ne 10f. Zip	Code		10	g. Citizen of Wh	nat Cou	
rith the Maryland s 23a or 28a-f show s s notified at once.	Director	10e. Street and Number  15001 Baden-V	Jestwo	od Road			102.,	20613			US	A	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral [	11. Marital Status		Was Decedent Ev Armed Forces?	er in U.S	. 13. W	as Decede Yes, specif	nt of Hispanic Orig	gin? ( Spec n, Puerto Ri	cify Yes or No- ican, etc.)		e - Amer e, etc.	ican Indian, Black,
er deat	Fun		vorced of Ye		No	1	Yes 2	X No specify:	:		Specify:	W	hite
urs afte tural"	d by	15. Decedent's Education (Sp	LorL	ates:	eted)	16a. Decede	nt's Usual	Occupation (Give	kind of wor	rk done	16b. Kind of Bu	usiness/	Industry
72 hou	Completed	Elementary/Secondary (0-12	)	College (1-4 or 5+)		-		king life. DO NOT			7	T	. E
Nothin rene.	d m	11				Heavy	Equi	pment O			Locust Maiden Surname		e rarms
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be C	17. Father's Name (First, Middle Samuel Jos	e, Last) Seph	Summ	ers,	Jr.		Venu	,	Eyve		ixo	n
212 ould be mark i mark	To B	19a. Informant's Name/Relation	nship (Type,	Print )		19b. Mailir		(Street and Nur					
MD nd 2 sho alth and m 27 is		Samuel J. Summ	ners,	Jr./Fath				len-West		Rd., B	20c. Location		MD 20613
ore, es 1 an of Hea If ite		20a. Method of Disposition  1 X Burial 2 Cremati	on 3 F	Removal from State	cr	rematory or c	other place						
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other 21. Signature of Funeral Service			Res			Cemetery  Address of Facili		7/2008			Maryland
Bal permi Depar Impo		Gauta &	hel	AA MO	0817		rins	ield-Ecl 30x I28,	hols Char	Funera lotte	l Home Hall, M	2 <u>°2€</u>	622
Physician	-	23a. Part I. Fater the disease, failure, List only one caus	or complicat	ions that caused th	e death.	Do not enter	the mode	of dying, such as	cardiac or r	respiratory arr	est, shock, or he	eart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease	se a. Mu	ltiple Gunshot									Death
4		or condition resulting in death)	b.	to (or as a conseq	uence or,	):							<u> </u>
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		to (or as a conseq	uence of	):							
	Examiner	(Disease or injury that initiated events resulting in death) Las	Due	to (or as a conseq	uence of	):							
(0, e be executed ysician and burial - transit													
O, e be ex ysician burial	edical	UNPENDED		MENDED	of progr	22004					23d. Date of	of delive	ery
3876 rtificat ing ph	an/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 2	3c. If yes, outcome		2 🗌 F	Fetal death	3 Ectop	oic pregnan	псу	Month		Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/M		Jnknown g	Pregnant at ti	me of dea	ath 5	Other (Spe	ecify)					
tal Records, P.O. Box 6876: rian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the 1		Part II. Other significant con			but not re	esulting in the	e underlyin	g cause given in F	Part I.				to the cause of death?
, P.O.	d by									1Ye	72.00		obably 4 Unknown
ords ** requires s been should	olete									24a. Was			autopsy findings available completion of cause of
Reco The la cate ha	Completed									1 🗸 Yes		1 🗸	
tal I ician: certifi rector,	Be	25. Was case referred to med examiner?		oital: 1 Inpatien	. 2	ER/Outpatie	ent 3	26.Place of Deat		g Home 5	Residence 6	<b>✓</b> Ott	ner: Scene
of Viji ing Physic After this	은	1 Yes 2 No		28a. Date of Injur	y	28b. Time o		28c. Injury at Wo	ork?	28d. Describe	how injury occu	ırred	
ion of Vital   tending Physician: eath. the funeral director,	i		ending vestigation	May 2, 2008		1350 hrs		1 Yes 2	No		ot by police		
Division of Vital Records, ta or Attending Physician: The law requir as after death.  In Director. After this certificate has been s led in by the funeral director, page 2 should 1	Certification: To	3 Suicide 6 C	ould not be	28e. Place of Inju		ome, farm, st	treet, factor	y, office building,	etc.	28f. Location or Town, 9709 Croom	(Street and Nun State) Road, Upper	nber or l Maribo	Rural Route Number, City oro, Md.
llospi 4 hou Suner		4 Momicide  29a. Certifier (Check only)  1 Certifying	Physician:	To the best of my	knawled	ge, death oc	curred at th	e time, date and p	place, and	due to the car	use(s) and mann	ner as si	tated.
To the Ilos within 24 h To the Fur completely	Medi	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signatu/A and title of certifier  29c. License number											Month, Day, Year)
	[	Unit	) '				=	O.C.M.E.			May 13, 2	2008	
Dal.		30. Name and address of per		npleted cause of de Medical Exam		123a) 111 Penr	Street,	Baltimore, M	D 21201	1			
	State	31. Date filed (Month, Day, Ye	ar)	32 Registrar			- M V						
Regi	stra	MAY 1	5 2001	1	0 0	19							
DHMH 17 Rev 1	/2001					ORIGIN	VAL						

Please Type or Print in Black Midelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month 5 :35 PM Adam Benjamin Strausner Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fahrney-Keedy Nursing Home Boonsboro Washington 8. Date of Birth
June 17, If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 1921 MB) Age (In yrs. last birthday) 220-16-1487 1X M 2 ☐ F 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Frederick 1 X Yes 2 No Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Larch Lane 21769 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1945 if Yes, Give Year or Dates: 1946 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☐ Xio Specify: Specify: White 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) assemblyman aircraft 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam B. Strausner Sr. Edna Middlekauf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Strausner (Wife) 18 Larch Ln., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methodyof Disposition 20c. Location - City or Town, State 1X Buria! 2 ☐ Cremation Fairview Cemetery 5/7/08 Keedysville, MD 4 □ Døn 5 ☐ Other (Specif Donald B. Thompson Funeral Home P O Box 18, Middletown, MD 21769 21. Signature of Forer Part1. Enter the disease, or complication shock, or heart failure. List only one care Approximate Interval Between Onser and Death ediate ause (Final resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Unknown ngs available of cause of Number.

**Physician** /Medical **Examiner** Box 68760

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

permit. Pages Department of Important: If it any Injury or o once.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

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Records,

Vital

or Attending

				.	1 Yes 2	No 3∏ Probably 4 🔀	
				-	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings a prior to completion of ca death? 1 □ Yes 2 □ No	
25. Was case referred to medical examiner?			26. Place of D	eath (C	heck only one)		
1 Yes 250No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 PANursing	Home	5 ☐ Residence 6	Cother (Specify)	
27. Manner of Death 1 SAiatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d.	. Describe how injury	/ occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f.	8f. Location (Street and Number or Rural Route Numb City or Town, State)		
29a. Certifier (Check only one)	rsician: To the best of my known iner: On the basis of examinating and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and pla ion, in my opinion, death oc	ice, and curred	due to the cause(s) at the time, date and	and manner as stated. place, and due to the cause(s)	

29b. Signature and title of certifier

29d, Date signed (Month, Day, Year)

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RKHALID WASCEN OBC

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

		Please Type or	Print in Black of Maryland / De			_	_	ble.		
		For State Registrar		Certificate of			Reg. No.	000	1661	
ELR.		Decedent's Name (First, Middle, Last)				2. Date of De	eath		3. Time of Death	
Physicia /Medic		Donald E. Stu	11			Month May	6, Day 20	08	6:30 A M	
Examin	100	4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town,	or Location of Death		4c. County	of Death		
		5648 Stone Road		Frede				Frede	rick	
Funeral		5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last birtho	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v Year)	9. Birthpl Coun	ace (State or Foreign	
Director		219-46-3154 Usual Residence of Decedent	64 Yr	S.		July 29	9, 1943	Mary	1and	
land ow		10a. State 10b. County	10c. City, Town of	or Location				10	Od. Inside City Limits	
Mary I-f sh fied a	ţ	Maryland Frederick	Fr	ederick					1 □Yes 2 No	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	try?	
th wit 23a c		5648 Stone Road			21703		Unit	ed St	ates	
ours after death w ral", or Items 23a Examiner must b	Funeral	11. Marital Status 12. Was De Armed F	cedent Ever in U.S.	13. Was Decedent of If Yes, specify Cub		ecity Yes or No	14. Rac	ce - America		
or It		1  Never Married 2  Married 1  Yes If Yes, G	2 <b>∑</b> No iive	1 □ Yes 2 📉 No		, , , , , , , , ,		v: Whi		
hours tural"	d by	3 ☐ Widowed 4 ☐ Divorced Year or		ecedent's Usual Occu						
n 72 ho "natur	lete	15. Decedent's Education (Specify only highest grade completed	9 (9	Give kind of work done ife. DO NOT use retire		ing	16b. Kind of B	usiness/inc	ustry	
filed within Hygiene. rther than "	Completed	Elementary/Secondary (0-12) College	(1-40r 5+)	acility Te				Banki	n.c	
be filed within 72 ho tral Hygiene. Id other than "natu event, the Medical	0	17. Father's Name (First, Middle, Last)		actively in	18. Mother's Name	e (First, Middle			iig	
ld be fenta rked tlc ev	0	Harold L. Stull			Keihol	.tz				
s ma	F33	19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Address (Stree	t and Number or Rur	al Route Numb	er, City or Town,	State, Zip	Code)	
and 2 salth n 27 i		Briony Foreman / Daughte	er 442	East Patr	ick St.	Frederi	ck. MD	21701		
of He rice of the		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from		isposition (Name of crematory or other pla	ace)	Date	20c. Location	- City or To	wn, State	
Pag ment ant:		4 ☐ Donation 5 ☐ Other (Specify)	Mt. Oli	vet Cemete		/2008	Freder	ick, l	Maryland	
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiens   Important: If item 27 is marked other than "n any Injury or other traumatic event, the Medione.		21. Signature of Funeral Service Licensee	1.		ess of Facility St.					
<u> </u>		Journey Stay	ye7		ssumtown			k, MD		
STEEL STEEL		23a. Pert1. Enter the lise of , or complications the short, or heart failure. List only one cause					arrest,		Approximate Interval Between Onset and Death	
Physician /Medicai		immediate Cause (Final disease or condition resulting in death)	tastatic		Cance	21			54	
Examiner		Due to	o (or as a consequence of)	-					,	
	er	Sequentially list conditions, b.	(or as a consequence of)	P						
tuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
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The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical	d								
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at the de by the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pret 9 ☐ Unknown 9 ☐ Unk	gnant at time of death nown	5 ☐ Other (specify) _					- u,	
that t		Part II. Other significant conditions contributing to	death but not resulting in t	he underlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to th	e cause of death?	
d by						1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
w requir s been si should	Completed					24a. Was	an 24b.	Were auto	osy findings available	
sician: The law certificate has b rector, page 2 s	omp						psy ormed?	prior to cor death?	npletion of cause of	
	BeC	25. Was case referred to medical			26. Place of Deat	1  Yes		1 ∐Yes	2 □ No	
Physici this ce al direc	To B	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outp	atient 3 DOA Ot	her:	,	idence 6 □Otl	ner (Specif	<i>(</i> )	
fer fer		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred United Section 1.5 Pending Se								
tendl eath. tor: A the fu	catio	2 Accident investigation M 1 ☐ Yes 2 ☐ No								
or At or At Olirec in by	Certification:	4 Homicide determined 28e. Plac	ce of injury - At home, farm ding, etc. (Specify)	n, street, factory, office		28f. Location ( City or To	(Street and Num wn, State)	ber or Rura	I Route Number,	
poltal Durs a neral I		29a. Certifier 1 Certifying Physician: To the	ne hest of my knowledge	death occurred at the	time date and place	and due to the	anuna/a) and m	onnor on of	ented	
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	(Check only 2 Medical Examiner: On the	basis of examination and/ nner stated.	or investigation, in my	opinion, death occur	red at the time	, date and place,	and due to	the cause(s)	
To the vithin To the somple	Me	29b. Signature and title of certifier	17	29c. Licen	se number		29d. Date signe	ed (Month,	Daly, Year)	
		1/5/ a		1.0	48184		516	10)		
10		30. Name and address of person who completed cal	use of death (Item 23a) (T	ype, Print)	1	,	1/ 11	N ^	1701	
٧		Elhamy Eskander, M	10 501	W 77h S	reet tre	deric	ry M	NJ	1/0	
Sta Registr		31. Date filed (Month, Day, Year) 32. MAY 0 7 2008	Registrar's Signature	4 1 1						
OHMH 17 Rev 1/20		0 1 2000	use of death (Item 23a) (Tyles of death (Item 23	2 Moser						

Physicia /Medic	_	- State Registrar Amended#5&12perFH FCHD  1. Decedent's Name (First, Middle, Last)				2. Date of De		Year 3. Time of Beath	
		Leo Schwartz		_		May 2,	2008	2:47 P.	
Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of		
		Sunrise Assisted Living		Frede:	rick  If Under 24 Hrs.	8. Date of Bir	Frede		
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yill 1974) 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rs. last birthday)  Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	9. Birthplace (State or Fore Country) Pennsylvania	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director			City, Town or Lo Frederic					10d. Inside City Lim 1 Yes 2 □ N	
		10e. Street and Number  2666 Brook Valley Road		10f. Zip Code <b>21701</b>				10g. Citizen of What Country?  USA	
burs after death v ral", or Items 23a Examiner must	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ■ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  14. Was Decedent Ever in Armed Forces?  15. Was Decedent Ever in Armed Forces?  16. Was Decedent Ever in Armed Forces?  17. Was Decedent Ever in Armed Forces?  18. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. - <b>white</b>	
ed within 72 hor ygiene. Ner than "natura t, the Medical E Completed		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	completed) (Give kind of work done life. DO NOT use retin		during most of work d)	ing	_	16b. Kind of Business/Industry	
2 should be filed w and Mental Hygie Is marked other t aumatic event, th To Be Co	17. Father's Name (First, Middle, Last)  Meyer Schwartz	MIU .	Mid level manager  18. Mother's Name (First, Midt  Mary Kline			Drug store  dle, Maiden Surname)			
and 2 should salth and Men n 27 is marke er traumatic	၉ .	19a. Informant's Name/Relationship (Type. Print)  Margaret Morin – daughter		-	and Number or Rui				
Department of Health Important: If item 27 any injury or other tr.		i Buriai Accremation 3 Herrioval Ironi State	o. Place of Dispo cemetery, crer	osition (Name of matory or other place Crematory	ce)	Date	20c. Location - 6	City or Town, State	
Depart Import any inj once.		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	10		sumtown P	ike, Fr		al Home Maryland 21 Approximate	
cate has been signed by the attending physician and bags 2 should be detached for use as the burial-transit bags and Completed by Physician/Medical Examiner	cal Ex	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Onset and Death							
	ıysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Mor	e of delivery nth Day Year	
	by	Part II. <b>Other significant conditions</b> contributing to death but not r	en in Part I.	23e. Did tobacco use contribute to the cause of death					
	omplet						24a. Was an autopsy findings availal autopsy performed? 1 ☐ Yes 2 ☐ No  24b. Were autopsy findings availal prior to completion of cause of death?		
ate has b	O	07.11							
ate has b	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deat			Assisted liv	
After this certificate has b funeral director, page 2 sl	To Be		28b. Time of Injury	f 28c. Inju Wor	ner: 4 🗆 Nursing Ho	ome 5 ☐ Res 28d. Describe 28f. Location	idence 6 Othe how injury occurre	er (Specify)	
oppore or Areaning Priyablan. The law hours after death.  uneral Director: After this certificate has b ly filled in by the funeral director, page 2 si	Certification: To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - Ai	28b. Time of Injury  t home, farm, strecify)	f 28c. Inju Wor M 1 Creet, factory, office	ier: 4 Nursing Hory at ry at rk? I Yes 2 No	28d. Describe 28f. Location City or To	idence 6 Other how injury occurred Street and Number win, State)	er (Specify) ed er or Rural Route Number,	
weathdeathdeathdeathdeathdeathdter this certificate has by the funeral director, page 2 sl	Medical Certification: To Be	examiner?    Yes   2  No	t home, farm, str ecify)  knowledge, deat ination and/or in	f 28c. Inju Wor M 1 Creet, factory, office h occurred at the ti vivestigation, in my 1 29c. Licens	ner: 4 Nursing Hory at rk? Yes 2 No	28d. Describe 28f. Location City or To	how injury occurred Street and Number win, State)	er (Specify) ed er or Rural Route Number,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 11:18 A M 2008 04 25 Willis William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 🔯 M Director 404-30-0887 02 10 1932 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Kensington Director MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20895 9918 LaDuke Drive Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs. Telecommunications Analyst U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Willis Jessie Childs ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delores Lincoln-Willis/Wife 9918 LaDuke Drive Kensington, MD. 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 07-17-2008 | Arlington, VA. 4 □ Donation 5 □ Other (Specify) Arlington National 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee Phaska 4217 9th. St. N.W. Washington, D.C. 20011 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as sinonsequence of) Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1∐ Yes 2₹ No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 X DOA ို After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

30

To the Hospital within 24 hours a To the Funeral E

Eddie A. Fernandez MD 1500 Forest Glen Rd. silver Spring, MD 20910 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

MAY 0 6 2008

29a, Certifier

Medical

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D64008

29d. Date signed (Month, Day, Year)

04-25-2008

# $\omega_{ILScN}$ Helem Baltimore, Maryland 21215-0036

3760,	
. Box 68	
rds, P.O	
tal Reco	
on or Vi	
Division	

	For 5-7-08 State of Mary and 7 Dep State of Mary and 7	ertificate of Death	Reg. No. 2 3 Time of Death
sician	HELEN WILSON		Month Day 2008 12:07 P
edical miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4cl County of Death
	DOCTORS COMMUNITY HOSPITAL	LANHAM	PRINCE GEORGE'S
ral tor	5. Social Security Number  431-58-9277  Usual Residence of Decedent  6. Sex 1 □ M 2x F  7. Age (In yrs. last birthday 97  Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Year)   9. Birthplace (State or Fore Country)   1.0
once.  To Be Completed by Funeral Director	10a. State 10b. County 10c. City, Town or L  Maryland Prince George's	ocation Upper Marlboro	10d. Inside City Lim
Director	Arkansas Hot Spri	ngs	
Dire	10e. Street and Number 5613 North Marwood Blvd.	<sup>10f. Zip Code</sup> 20772	10g. Citizen of What Country?
Funeral	2818 S- Spring Street           11. Marital Status         12. Was Decedent Ever in U.S.         13	72206 Was Decedent of Hispanic Origin? (Specity	United States  Yes or No- 14. Race - American Indian,
듄	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ■ No	If Yes, specify Cuban, Mexican, Puerto Rica	an, etc.) Black, White, etc.
by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black
Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
d m	Elementary/Secondary (0-12) College (1-4or 5+)	tered Nurse	Health Care
Be Cc	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)
70 B	Lucius Anderson	Annie J. W	/ilkins
		ling Address (Street and Number or Rural Re	oute Number, City or Town, State, Zip Code)
			d, Upper Marlboro, Md. 20
	20a. Method of Disposition  20b. Place of Disposering State  20c. Method of Disposition 3 □ Removal from State	position (Name of Date ematory or other place)	20c. Location - City or Town, State
		ip Cemetery 5/15/2	2008 Hot Springs, AR
ouce		22. Name and Address of Facility Pope	
Zi I	23a. Part1: Enter the disease, or complications that caused the death. Do not en		prestville, Maryland 20747
	shock, or heart failure. Listonly one cause on each line.	-, -, -, -, -, -, -, -, -, -, -, -, -, -	Onset and Death
an cal	disease or condition resulting in death)  a. Se///  Due to ( r as a consequence of):		Unknown
er	decubitus ulcer		Maknown
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
a E	Due to (or as a consequence of):		
gi	d		
Medical Certification: To Be Completed by Physician/Medic		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
l by	At Dementia	, ,	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unkn
Completed			24a. Was an 24b. Were autopsy findings avail
dw		_	autopsy prior to completion of cause performed?
ပိ	25. Was case referred to medical	26. Place of Death (C	
O B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	ent 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
J: T	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury	of 28c. Injury at 28d	I. Describe how injury occurred
cati	2 Accident investigation	M 1 Yes 2 No	The state of the s
Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	areer, ractory, office 281.	. Location (Street and Number or Rural Route Number, City or Town, State)
ပိ	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, de		
<u></u>	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	Investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
dica	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Medical		1 /)	5.2.08
Medical	Reinta Frankl M.D.	043446	7,2.00
Medical			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	•	artment <i>tificate</i>			d Men		ene	8 1664	17
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	White	>	•				Date of Death Month	1 Day 30 30	3. Time of Dec	ath 4M
	Examir Funeral Director		5. Social Security Number 6. Sex	Well Sel Conte	ast birthday) Yrs.	If Under 1	no	Location of D A D D If Under 24 I Hours N	Hrs. 8. 1	Date of Birth Month, Day, Ine I	4c. County of Anne (Year) 1933	1 1 0	oreign
	Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru		, Town or Lo							10d. Inside City L 1 ☐ Yes 2	_
	h with the	Funeral Director	10e. Street and Number 996 Generals Hig	hway		10f. Zip (	Code 2.1.03	32		10	g. Citizen of Wh	at Country?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ifem 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, It is Modical Examinational to notified at	by	11. Marital Status  1  Never Married 2 Married  3 XWidowed 4 Divorced	Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decede f Yes, specif		spanic Origin' n, Mexican, Pi Specify:	? (Specify uerto Rica	Yes or No- n, etc.)	Black,	American Indian, White, etc. Black	
21215-0036	filed within 72 ho Hygiene. ther than "natur ent, trie Moules!	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 1.2 th	ion ompleted) College (1-4or 5+)	(Give life. I		done di retired)	tion uring most of partme		1	6b. Kind of Busi Crowns Hospit	ville	
Maryland	ould be filed Mental Hygis tarked other tatic event, II	To Be C	17. Father's Name (First, Middle, Last) Vernon Edwards							rst, Middle, M Vatkir	laiden Surname) 15		
	and 2 should I saith and Meni 27 is marke er traumatic		19a. Informant's Name/Relationship (Type Kimberly White(D								City or Town, St 1SVill∈	ate, <i>Zip Code)</i> 2., Md. 210	)32
Baltimore,			20a. Method of Disposition  1	ioval from State	ace of Dispo emetery, cren rylan	natory or oth d Vet	er place er a	n 5-	Date -6-08	3 (	Crownsv	tyorTown,State rille, Md.	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	n00483							Md. 2		
	Pnysician	8 1	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death cause on each line.	. Do not enti	er the mode	of dying	, such as car	rdiac or res	spiratory arre	st,	Approximate Interval Betwee Onset and Deal	
	/Medical Examiner		resulting in death)  Sequentially list conditions.	Due to (ir as a consequ									
0,	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		· · · · · · · · · · · · · · · · · · ·							
68760,	tificate be ig physicie as the bur	ledicai	( d										
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1								23d. Date Month		r
٥.	quires that an signed b uid be deta	by	Part II. Other significent conditions contri			nderlying cau	use give	n in Part I.				ute to the cause of death	
Il Records,		Completed								24a. Was an autopsy perform 1 🗆 Yes 2	ed? de:	re autopsy findings avai or to completion of cause ath? I Yes 2 \( \square\) No	ilable e of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	pital:			Othe	-		eck only one			
of	Ite ne	F-	1 Yes 2 No Plos  27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury Work	4			nce 6 Other v injury occurred		
Division	al or Attending s after death. Il Director: After ad in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At ho building, etc. (Specify	me, farm, stre )	et, factory,	office			Location (Str City or Town,		or Rural Route Number,	
	To the Hospital or Atter within 24 hours after de To the Funeral Direct completely filled in by th	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	an: To the best of my know: On the basis of examinati and manner stated.	wledge, death ion and/or inv	estigation, i	n my op	inion, death o	lace, and occurred a	t the time, da	te and place, an	d due to the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier  Imy R Crwd	UMD H	ospiluli	29c.	License	number 5 7 0			d. Date signed ( $\frac{1}{30}$	Month, Day, Year)	
CH.	+5		30. Name and address of person who comp	r,M) 200	1 Me	Print)	Par	-kwa	y A.	napo	lis MO	21401	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 200	32. Registrar's Signat		book	,						_

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 Month Year 3 4:30 P M SOLOMON MAY LEE WILLIAMS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 1X M 2□ F 1936 578-50-1788 JULY 12 VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County X☐Yes 2☐No PRINCE GEORGE'S SPRINGDALE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8911 BOLD STREET 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ XMarried BLACK 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT 12th ELECTRONIC TECHNICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALFRED WILLIAMS HATTIE CARTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA WILLIAMS/WIFE 8911 BOLD STREET SPRINGDALE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5/10 2008 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CALVARY BAPTIST CHURCH MT. 4 ☐ Donation 5 ☐ Other (Specify) ORANGE, VIRGINIA 21. Signature of Juneral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or/as a consequence of) 5 ( 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 1 No 1□ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

the Medical

traumatic and N

marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trau

d 2 should be fi th and Mental H

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

Box 68760.

P.0.

Division or Vital Records,

Examine bunal-tran and physician the as nse for

Physician/Medical þ 2 should Completed

Be

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Certification:

Medical

the

filled in by

the Hospital of within 24 hours a

To the Funeral D

be executed signed by the certificate has page this al or Attending P s after death. Il Director: After t After t

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

investigation

6 Could not be determined

28c. Injury at Work?

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number 000 3 70 6 6

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11. Lo. L: 7 Opaigbeogu. m.D 6/880 ton Hill Rd # 701, Of on Hill, MD 20745 31. Date filed (Month, Day, Year) 32. Registrar's Sign

State Registrar

2008 MAY 0 8

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** May 4, 2008 8:22 A Vannette E. Wiley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months 1 M 2004 1939 578-50-9926 68 May 29, Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☑ Yes 2 ☐ No Director Maryland | Prince George's District Heights 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1912 Glendora Drive 20747 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Black. Specify. Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Membership Records Manager 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Jones Mary Ellis P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7316 Donnell Place #C4 Forestville, MD 20747 Michele Brown - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l Mem Pk May 12, 2008 Laurel, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Serv 4001 Benning Road, NE Washington, DC 20019 23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cluse (Final Cardiopulmonary Arrest Approximate Interval Between Onset and Death Cardiopulmonary Arrest disease or condition resulting in death) Due to (or as a consequence of) Respiratory Failure Sequentially list conditions, if any, cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Medical Examiner Sepsis Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐ Yes 2 XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death Check onl one

**Physician** /Medical Examiner and

Baltimore, Maryland 21215-0036

use as the burial-trar attending physician þ should be detached page 2 director,

Physician	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown
þ	Part II. Other signifi
Completed	
Comp	
lo Be	25. Was case referrexaminer? 1 ☐ Yes 2 ☒ [
ion: To	27. Manner of Death 1 X Natural

1 Yes 2 No

2 ☐ Accident

3 ☐ Suicide

4 Homicide

Medical Certifical

or Attending Physician: The law requires that the death certificate be executed the nours after death.

neral Director: After this

filled in by the funeral d

Division or Vital Records, P.O. Box 68760

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and little of certifie

5 Pending

investigation

6 Could not be determined

1X Inpatient

(Month, Day Year)

28a. Date of Injury

29c. License number

D065069

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d, Date signed (Month, Day, Year) May 4, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sirak Lemma
31. Date filed (Month, Day, Year)
MAY 0 8 2008 500 Forest Glen Road Silver Spring, MD 20701

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend I tem 28 f Der and 1880 16/09/ Pedin and Mental Hygiene 1- For State Amend #25,27,28a-f, perME, g879 5/30/08ertificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 1:10 a.m. 14, 2008 James Lenderman Wilbar Sr. May\_ /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Charlotte Hal Ha11 Charlotte Hall Veterans Home Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 06/24/1923 Washington, DC Director 577-28-8226 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director California Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or Items 23a or 20619 United States 24131 N. Patuxent Beach Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Margaret Micheljohn 2 Jesse Lenderman Wilbar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health a James L. Wilbar, Jr./Son 10728 Dublin Road, Walkersville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/20/2008 | Washington, DC Rock Creek Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Si patro del Funeral Servi Licensee Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZHEIMER'C **Physician** /Medical Due to (or as a consequence of) **Examiner** KIDNE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner geath cartificate be executed as the burial-tran APAROLED BY MEDICAL EXAMINER 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 DEctopic pregnancy Month in the past 12 months? 5 Other (specify) 1 Tyes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown SUB DURAL HEMATOMA 2007 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autops, performed: 'as 2 No 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nafsing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 1 Inpatient ō uneral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 ☐ Yes 2 😿 No investigation Find 11/19/2007 unk. 2 Accident probable fall. Il Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State) Find. Route Number, 3131 N. Patuxent 4 Homicide found-home Beach Rd. California, MD Funeral 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 h To the Fu (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MAY 1 6 2008 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

### 08-Trac

Physician/ 1 LExaminer	gistrar	Oci timodio o	f Death	Hygiene <sub>Reg.</sub>	No.	0 0 8 6 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Examiner	Decedent's Name (First, Middle,Last)  TRACEY LEE YANCY			2. Date of Death Month D May 12, 200	ay Year 8	2025 hrs
<i>F</i>	a. Facility Name (if not institution, give street and number) Harford Memorial Hospital		4b. City, Town, or Location of De Havre de Grace		4c. County of Dea Harford	
-uneran		e (In yrs. last birthday) 25 Yı	If Under 1 Year If Under 24 Months Days Hours I	V		Birthplace (State or eign Country) MARYLAND
any	Isual Residence of Decedent  Oa. State 10b. County	10c. City, Town or Loca	ation HAVRE DE GRA			10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f shoviffied at once.	MARYLAND HARFORD  10e. Street and Number  110 VANCHERIE COURT		10f. Zip Code 21078	10g	. Citizen of What C USA	ountry?
s 233	11. Marital Status  1 X Never Married 2 Married Armed Forces  1 Yes 2		Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu  Yes 2 X No specify:	( Specify Yes or No- erto Rican, etc.)	14. Race - An White, etc	1
"natural", c	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade continuous)  Elementary/Secondary (0-12) College (1-4 or	mpleted) 16a. Deced	lent's Usual Occupation (Give kind most of working life, DO NOT use		16b. Kind of Busine	
ited within 72 hours aft. Hygiene. Joher than "natural" the Medical Examine Completed by	12 17. Father's Name (First, Middle, Last)			Name (First, Middle, M	laiden Surname)	STORE
and Mental Hi 77 is marked of matic event, II To Be (	BERNARD YANCY  19a. Informant's Name/Relationship (Type, Print)  PEGGY L. YANCY / MOTHER	19b. Mai	ling Address (Street and Number STANSBURY COUR	r or Rural Route Num	ber, City or Town, S	MD 21078
permit. Pages I and 2 st Department of Health an Important: If item 27 injury or other trauma	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from S	20b. Place of Dis	position (Name of cemetery, rother place)  MEMORIAL GRDS	Date	20c. Location - Cit	ty or Town, State EEN, MARYLAND
executed an and fedical Examiner ical Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  Due to (or as a condition of the condition o	Lam and met nsequence of):  nsequence of):  nsequence of):  ,28a-f, per come of pregnancy	hadone intoxica	tion	est, shock, or heart  23d. Date of d	Between Onset and Death
we requires that the death certificate be execused by the attending physician as been signed by the attending physician at should be detached for use as the burial - I pleted by Physician/Medica	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to do	t at time of death 5	The underlying cause given in Par	1 23e. Did	es 2 No 3	Probably 4 Unknown  There autopsy findings available for to completion of cause of
ysician: The law requires that his certificate has been signed director, page 2 should be dettered.	25. Was case referred to medical		26.Place of Death	perf 1 ✓ Yes (Check only one)	ormed? de 2 No 1	eath? Yes 2 No
To the Hospital of Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burning Madical Certification: To Be Completed by Physician/Med	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending Investigation  3  Suicide 6 X Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the best one)  29b. Signature and title of certifier  30. Name and address of person who completed cause	nay, Year) 12/08 Fnd of Injury - At home, farm residence of my knowledge, death examination and/or invited.	7:42 pm 1 Yes 2 X  n, street, factory, office building, et occurred at the time, date and placestigation, in my opinion, death of 29c. License number O.C.M.E.	c. 28f. Location or Town 124 St ace, and due to the cacurred at the time, da	ansbury Couse(s) and manner te and place, and de 29d. Date sign.  May 13, 20	er or Rural Route Number, Cli MID Ct. Havre de C as stated. ue to the cause(s) ed (Month, Day, Year)
Stat Registra	e 31. Date filed (MorMAY, Year) & 2008 32. P	istrar's Signature	fork			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

08-03560 Gilbert Young Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

JIIDOIT 10	ong		For State of Ivial yland / E	Certificate of		and mone		Reg. N	. 200	18 1665
	hysicia	ın/	I. Decedent's Name (First, Middle,Last)				Mo	te of Death onth Day	Year	3. Time of Death 2105 hrs
Medical I	Examii	ner	Gilbert F. Young  a. Facility Name (if not institution, give street and number)		4b. City, Town	, or Location of		y 9, 2008	4c. County of Dear	
!			Southern Maryland Hospital		Clinton				Prince Georg	e's
	ineral		5. Social Security Number 6. Sex 7. Age (II	n yrs. last birthday)	If Under 1	Year If Under Days Hours	Min		M/DD/YYYY) 9. B Fore	ign Wash.
Dir	ector	-	579-64-2352 1X M 2 F Usual Residence of Decedent	58 Y	rs.	Day Trouis	0	8-31-	1949 C	ountry) DC
	any	-		c. City, Town or Loc	cation					10d. Inside City Limits
and	show	5	MD Prince Georges	Cli	nton_					1 X Yes 2 No
Maryl	r 28a-f	Director	10e. Street and Number		10f. Zip Coo	<sub>de</sub> 20735		10g. C	Citizen of What Co	untry?
S   S	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at ones.	ral D	7906 Colonial Lane  11. Marital Status   12. Was Decedent Ev		Was Decedent o	f Hispanic Origin				erican Indian, Black,
death v	r item	Funeral	1 Never Married 2 Married Armed Forces?		f Yes, specify Co	uban, <b>M</b> exican,	Puerto Ricar	i, etc.)	White, etc.	
after	ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X		ind of work d	one   161	Specify: b. Kind of Business	Black
2 hours	"natu Exan	Ē.	15. Decedent's Education (Specify only highest grade completed by Elementary/Secondary (0-12) College (1-4 or 5+)		most of working			one no	y. Rand of Education	, madou y
036 ithin 7	r than Iedica	Completed	1	Pos	stal W					Office
<b>21215-0036</b> suld be filed within 7	Hygie d other		17. Father's Name (First, Middle, Last)  Morris Young				ie Th	t, Middle, Maid	en Surname)	
212' ald be	Mental marke event	To Be	19a. Informant's Name/Relationship (Type, Print )	19b <sub>0</sub> Mai	ing Address (				, City or Town, Sta	te, Zip Code)
MD d 2 short	th and 27 is umatic		Catherine Young (Wife)	Cli 20b. Place of Disp	nton,	Maryla	nd	20735		
re, I	f Heal If item		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State		osition (Name of other place)	of cemetery,	Dat	e 20	c. Location - City	or Town, State
Baltimore, <sub>permit. Pages 1 ar</sub>	ment o		4 Donation 5 Other Specify:	Riverda				5-08		ale, MD
Balt permit	Depart Impor Injury		21. Signature of Funeral Service Licensee		Ralph	Willia Willia	ms Fu	neral,	Servic Wash.,	e DC 20003
~ Phys	sician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the	e death. Do not ente	er the mode of d	ying, such as ca	ardiac or resp	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
	edical miner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atheroscle	rotic car	diovasc	ular di	sease			Death
			or condition resulting in death)  Due to (or as a consequence)	ence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):						
		Examiner	Colsease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseq	ience of):						
executed	physician and the burial - transit		d	<del>.</del>						
'60, ate be exe	sician burial -	Medical	X UNPENDED AMENDED 23a,27,pe	rME,g881	7/2/08	TT			23d. Date of deliv	000
876 tificate	ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome 1 Live birth	of pregnancy	Fetal death	3 Ectopic	pregnancy		Month	Day Year
Box 68 e death certif	attend or use	Physician	1 Yes 2 No 9 Unknown 9 Unknown	ne of death 5	Other (Specify,	)				
O. B.	by the ached f		Part II. Other significant conditions contributing to death b	ut not resulting in th	ne underlying ca	use given in Pa	ırt I.	23e. Did toba	cco use contribute	to the cause of death?
Division of Vital Records, P.O.	signed be det	d by						1 Yes		robably 4 Unknown
Ords w requi	should	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
Zecc The la	cate ha	mo						performe 1 Yes 2		
ital I	s certif rector,	B	25. Was case referred to medical examiner?   Hospital:	2 ✔ ER/Outpati		Place of Death	(Check only Nursing Ho		sidence 6 Ot	her:
of Vi	ter this	<u>۲</u>	1 Yes 2 No Patient 28a. Date of Injury	28b. Time		. Injury at Work	J		injury occurred	
On C	eath. or: Al	tion	1 X Natural 5 Pending 2 Accident Investigation (Month, Day,Yea	7)	1	Yes 2				
ivisi or Atu	after d Direct I in by	tifice	3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, s	street, factory, of	ffice building, et	c. 28f.	Location (Street or Town, State		Rural Route Number, City
Ospital	hours ineral y filled	Ser	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my leading to the control of the contro	enguladas, daeth as	nourred at the tir	ne date and nia	are and due	to the cause(s	and manner as s	tated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my k one) 2 Medical Examiner: On the basis of exami and manner stated.	nation and/or invest	tigation, in my or	oinion, death oc	curred at the	time, date and	place, and due to	the cause(s)
Ę	iw 🗗	Me	29b. Signature and title of certifier			icense number			9d. Date signed (	Month, Day, Year)
			Varyine Meldrell			D.C.M.E.			May 11, 2008	
0 1	1)		<ol> <li>Name and address of person who completed cause of dea Margarita Korell MD. Assistant Medical E</li> </ol>		1 Penn Stree	et, Baltimore	e, MD 212	01		
12/0	S	tate	31. Date filed (Month, Day, Year) 32. Registrar's		2 4	,				
	Regis		MAY 1 4 2008	7 A30040						

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4:25 AM 2008 Baby Girl Andrews MUU 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HUSPITAI The Johns Hopkins Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nay 15, 2008 Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔯 F Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2√☐ No Directo MD Washington Hagerstown death with the 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be r USA 21742 18705 Mesa Terrace by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Itel
Iry or other traumatic event, the Medical Examines 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Kamilah Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 21. Signatur i Funeral Sprice Sicensee, Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** exprime premamun 21 Minuks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any trading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9□Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, q 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 X No 2 **X**No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

State Registrar

31. Date filed (Month, Day, Year) MAY 2 2 2008

Julie Phillips

Rhulyn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 N. NOIFE . Registrar's Signature

29c. License number

- 000

Baltimore, MD

29d. Date signed (Month, Day, Year)

15,2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1008 Month **Physician** RINCON ABUNDEZ ANGEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER CROSS SPRING HOSPITAL MONTCOMER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) MARULANS 7. Age (In yrs. last birthday) 5. Social Security Numbank 6. Sex Year) 1 M 2 □ F 0 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No Funeral Director PG. 10a, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1306 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2□ No Specify þ OTHER 3 Widowed 4 Divorced MEXICAN Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than any injury or other traumatic event, the Me once. College (#-4or 5+) Elementary/Secondary (0-12) INFANI NFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MIARISSOL RINCON RODRIGUEZ ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FOREST GLEN RD SILVER SPRING MD 20910 1500 CROSS HOSPITAL HOLY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 NOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Service 1 Ronald S Licensee Wade Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock, Immediate Cau (Final disease or condition resulting in death) ORD AC **Physician** Due to (or as a consequence of): HOITANABE OF Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner PREMATURIT Due to (or as a consequence of): PRETERM Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ā 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi attending physician and Division or Vital Records, P.O. Box 68760, been signed by the a should be detached within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral To the Hospital

**Funeral** 

Director

ns 23a or 28a-f show must be notified at

Items 2

ò

"natural",

injury or other traumatic event, the Medical

/Medical

**Examiner** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certification: To 2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier

5 ☐ Pending investigation 6 ☐ Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 POREST GLEN RD SILVER SPRING MD 20910 FA

State Registrar 31. Date filed (Month, Day, Year) 2008 2

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yea Howard Edward Barnes 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Sept 10, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) . 1932 Days Hours Mary Land Months 75 217-28-5149 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Maryland | Washington Hagerstown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21740 **USA** 12540 W. Washington Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 DNo 1948 If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □Yes 2X No

Poker Dealer

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

and manner stated

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

ANTIETAM

9 Unknown

4 ☐ Pregnant at time of death

Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metro Crematory Inc. 05/22/08

3 Ectopic pregnancy

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

058853

HAGERSTOWN,

5 ☐ Other (specify)

Specify: White

16b. Kind of Business/Industry

Casino

20c. Location - City or Town, State

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Baltimore, Maryland

Approximate Interval Between Onset and Death

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 West Salisbury Street Williamsport, MD 21795

Date

Cremation Society Of Maryland, Inc.

Ellen Eileen Harbaugh

299 Frederick Road Baltimore, Maryland 21228

Lutarchun

24a. Was an

1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy

2

28d. Describe how injury occurred

**Physician** /Medical Examiner

Department of Health a Important; If item 27 is any injury or other tra

For State Registrar

10a. State

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

Howard Edward Barnes Jr., Son

1 ☐ Burial 2 Cremation 3 ☐ Removal from State

5 ☐ Other (Specify)

College (1-4or 5+)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

4 Donation

Immediate Cause (Final

Sequentially list conditions

rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 □Yes 2 □No

25. Was case referred to dical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 22

5 Pending investigation

6 Could not be determined

examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier (Check only one)

IF FEMALE:

disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

Ralph Moats Barnes

21. Signature of Buneral Service Life 12. Signature of Buneral Service

19a. Informant's Name/Relationship (Type. Print)

Director

Funeral

Completed by

Be

ဂ္

Examiner

Physician/Medical

2

Completed

Be

Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Mediral Expanier manal te notified at traumatic event, if a Mediral Expanier man te notified at

Baltimore, Maryland 21215-0036

be executed sician and burial-trans physician the burial attending p been signed by should be detach has

P.0.

Division of Vital Records,

The law requires that the death certificate page 2 certificate | To the Hospital or Attending Physician: director, this After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Year 17, **Physician** 11:00P M May Bucther Chester Hugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Hanover 1922 Canon Chet Court If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 20, 1948 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 □ F WV 59 236-78-2287 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County in than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Hanover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21076 1922 Canon Chet Court by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours effer and of Health and Mental Hygiene.
Inc. If item 27 is marked other than "natural; or flee and yor other traumatte event, Item Medical Exaction ury or other traumatte event, Item Medical Exaction 1 M Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Levene Sponaugly Herbert Stern Butcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8070 Castlerock Court Pasadena MD 21122 Mr. Benjamin M. Butcher/Son 20c. Locetion - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
eny injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation | 05/22/2008 | Stevensville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licenses Mo1357 Services 1 2nd Avenue SW Glen Burnie, MD 21061 Venue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOCARDIAL Physician /Medical **Examiner** TEHSIOH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by the attending physician tached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 D. No 3 Probably 4 Unknown 1 🗌 Yes has been signed as the signed to the signed Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 No certificate 2 No 1 Tes Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: Other: í¥Yes 2□No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. escribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08 1 MD 808 LANDMARIL DRIVE GLENBARNIE

Registrar's Signature mpleted cause of death (Item 23a) (Type, Print) Name and address of person who MEXTOI Z" 2008 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 10:00 A M Margaret Lillian Barrett May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 330 Bar Harbor Road Pasadena

| Hounder 1 Year | Hounder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 7, 192 Pasadena 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□M 2XF MD Director 220-14-6600 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "netural", or Items 23e or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e Street and Number 10f Zin Code USA 21122 330 Bar Harbor Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. "netural", or fler Important: if item 27 is marked other than "netural", or fler may injury or other treumatic event, the Medical Examina any. 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian Johnson Albert Dehn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 330 Bar Harbor Road Pasadena, MD 21122 Timothy J. Barrett 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State May 23 2008 \* 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Brooklyn, MD 22. Name and Address of Facility Singleton Funeral & Cremation Svs. 1 2nd Avenue., S.W. Glen Burnie, MD 21061 mar918 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat [ARCINOMA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Disease 1 ☐ Yes 2 ☐ No 3 ☐ Perbably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2/100 1 Yes 2 ZINO 1□ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Deatural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No hours after death. uneral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours. To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed; (Month, Day, Year) 12008 Attending Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C-V-CYRIAC-M.D 8021 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAY 2 2 2008

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year LACCIE C. **BROWN** 1911 PM 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square HospiTAL Center Rosedale Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) MAY 2, 1923 Birthplace (State or Foreign Country) Days Min. Months 1 XM 2□ F 228-22-2683 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No BALTIMORE **ESSEX** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1311 GOODWOOD AVENUE USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 □Yes 2 🔼 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TALLEY CLERK BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDDIE BROWN JEANETTE SPRATLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE BROWN/SON 770 VILLAGER CIRCLE, DUNDALK, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL MEM. PK 05/24/2008 | MIDDLE RIVER, MD21220 4 Donation 5 Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 ames a. 23a. Part. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final FaTaL Arrythmia disease or condition resulting in death) /cardiac Due to (or as e consequence of): Atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Directo

Funeral

ð

Completed

Be ည MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

200

physician and the burial-trans signed by the attending physician I be detached for use as the buria page 2 should be

Examiner Physician/Medical Š Completed Be Certification:

1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending investigation

6 Could not be determined

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54428

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 3:43 P M MAY William Joseph Barrett /Medical 20 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL BALTIMORE 5. Social Security Number 6. Sex ↑ M 2 F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) Maryland Director 216-30-5094 April 9 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes Ž No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 504 Sudbrook Lane 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Korea Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Never Married 2 ☐ Married Maryland 21215-0036 ģ 1 ☐ Yes 2 🎇 No Specify Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Insurance Specialist Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine James Carroll Barrett Laws 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7610 Seven Mile Lane, Pikesville, Maryland 21208 Patricia Wellbrock / Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 5/23 / 08 Pikesville. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the eral Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER a. METASTATIC MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the country of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 nh onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.

neral Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RUS 000

12+1 State

2111142

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NOONN

PATIENT

Registrar DHMH 17 Rev 1/2001 SINAI

32 Registrar's Signature

MA

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENGUPTA

SOMA

31. Date filed (Month, Day, Year)

MAY ZO,

HOSPITAL OF BALTIMORE, BACTIMORE, MDZIZIS

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 03:45a M Marie S. Bennett May 20 2008 /Medical 4c. County of Death cility Name (If not institution, give street and **Examiner** towaro vina 1:cott If Under 24 Hr Birthplace (State or Foreign Country) If Under 1 Year Date of Birth Month Day, (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 💢 F 9-44-0805 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 Yes 2 No :COT Director Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numb 6 within 72 hours after death with 043 2 "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 XNo Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired nion than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumatic event, Item 200ce. le (First, Middle, Maiden Surname) 18. Moth . Famer's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Numb onstance Baltimore, 20c. Location - Cit 20b. Rice of Disposition 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) e of Funeral Service Licensee 51517821to. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Essential Hypertension 30 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or injury. Examiner Due to (or as a consequence of) be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the Se IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Ye ar 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No o 9 Unknown σ. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performe After this certificate 2 **X**No 1 □ Yes 2 **X** No Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Assisted 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 Inpatient 5 ☐ Residence 6 MOther (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Living 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending within 24 hours after common to the Funeral Director; Aft

To the Funeral Director; Aft

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.()D56531 - May 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 为五 Harry Li, 8600 Snowden River Pkwy, Ste 301, Columbia, MD 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

08-03758 Jason Batts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death Decedent's Name (First, Middle Last) Physician/ Month Day May 17, 2008 0306 hrs Medical Examiner ridger asor c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia 5894 Stevens Forest Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** oreign Hours Months Davs Country) Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No or 28a-f show lumbia towar s 23a or 28a-f sho jes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Was Decedent Ever in U.S. Funeral White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Armed Forces? 2 Married Yes 2 No specify: Divorced If Yes, Give Year ۵ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) d other than " ec 94 Mother's Name (First, Middle 17. Father's Name (First, Middle marked Be 19b. Mailing Addr 19a Informant's Name/Relationship ( Baltimore, MD 20b. Place of Disposition (Name of cemetery, Method of Disposition crematory or other place) 2 Cremation 3 Removal from State ici d 5 Other Specify. 22 Vaughess ature of Funeral Service 21. Sig (21229 Pilce. 5151 Baito. Nat'I Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Enter the disease, or complication failure. List only one cause on each line. Between Onset and Physician Death /Medical a. Shotgun Wound to the Back Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED ted by the attending physician detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Month Year Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 1 Yes 2 No 3 Probably 4 signed b Š 24b. Were autopsy findings available Completed Division of Vital Records, 24a. Was an has been s prior to completion of cause of autopsy death? performed' 2 No ✓ Yes 2 No 1 🗸 Yes certificate h 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene Hospital: 1 examiner? DOA ER/Outpatient 3 Inpatient 2 this No ို 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury After 27. Manner of Death Subject shot May 17, 2008 Certification: 0249 hrs 1 Yes 2 ✔ No Natural Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5894 Stevens Forest Road, Columbia, Md. Could not be Suicide (Specify) Inside parked vehicle Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 17, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD Registrar's Signature 22 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death dent's Name (First, Middle, Last) Month Year **Physician** Z:55 PM Dowman 2008 homas /Medical 4c. County of Death Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner < Nursing Baltimore ttome 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country Age (In yrs. last birthday)
Yrs. Security Number **Funeral** Hours 1 M 2 □ F 250-36-2028 Director filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Fown or Location 10d. Inside City Limits or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Depertment of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or iteme 23a or 28a-1 ehov any Injury or other treumatic event, the Madical Examiner must be rediffed at once. Balti more Vood lawn MD 1 Yes 2 □No Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ISA 3101 21244 Koa 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Motor Colfege (1-4or 5+) 7. Father's Name (First, Middle, Last) Aother's Name (First, Be Bowman onn:e Didner Marshal ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pript) Batto. mD 21236 Thomas Bowma Baltimore, 20b. Place of Disposition (Name of semetery, crematory or other place, Date 20a. Method of Disposition 1 Buriaf 2 ☐ Cremation 3 Removal from State Baltimore 21.08 tac 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Myland Address of acili Greene Funeral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Artery DISECULE nkrow Dronery /Medical Due to (or as a consequence of): Examiner ASTROCYTOMA 22 Klam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed lioblastona Unklam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ ANCER 1 Yes 2 No 3 Probably 4 Winknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate hes 2 No 1 ☐ Yes 25. Was case referred in medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled it 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cortilio 29c. License number 29d. Date signed (Month, Day, Year) 16/08 Dallet Salva Mo D0059056

Registrar
DHMH 17 Rev 1/2001

State

West

40th St

700

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvi

MAY 2 2 2008

jeet

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend it am 17 per ft 9879 5-22-08vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death -200E **Physician** Butter -16-/Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospice Cé imore If Unde Date of Birth (Month, Day, 7. Age (In yrs. last birthday) f Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours 1 ☐ M 2 💢 F Months Davs **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-5 show any injury or other traumatic event, It will deal Exam from a cust by mention and injury or other traumatic event, It will deal Exam from a cust by mention and injury or other traumatic event, It will be a considered and injury or other traumatic event, It will be a considered as a considered and injury or other traumatic event, It will be a considered as a considered as a considered and injury or other traumatic event, It will be a considered as 1 □Y 2 □ No Director timore 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ■No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) noma s ora 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sale, Zip Code) Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/22/2008 Balfo.MD 21. Signature of Funeral Service Pol. 12000 MID 21212 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onton **Physician** disease or condition resulting in death) cueller /Medical Due to (or as a sequence of) Examiner week Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed month physician and the burial-trans Due to (or as a consequence of) Physician/Medical AVCIUNOMA un Drumm use as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ heumatoid 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate of Vital 1 □ Yes 2 No 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation r death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MAY 16, 2008 25205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. MV 2120x Bine 6 6701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2

gistrar's Signatur

32.

2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 19,2008 MAY 8:35A M John William Beall 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 □ F 68 MD 214-38-3191 26 1939 Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2√☐ No Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21131 USA 13200 Jarrettsville Pike Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces XYes 2 □ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Boiler Technician Genstar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Preston George Beall Sr. Mary Eva Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) V. Rosalie Beall/wife 13200 Jarrettsville Pike, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5/23/08 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. LO W. Padonia Rd., Timonium, MD 21093 Bryan W. Clar 23a. Party Enter the disease, or complication, that caush ck, or hear failure. List only one cause on ead Immeditie Cause (final disease at condition ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death ONE HOUR MYOCARDIAL INFARCTION ACUTE disease or conditi resulting in the Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

a or 28a-f show be notified at

items 23a c iner must be

'natural", or

Hygiene.

s 1 and 2 should be filed w if Health and Mental Hygier item 27 is marked other thother traumatic event, the

pormit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau

Director

Funeral

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Completed

Be

the Maryland

within 72 hours after death with

Baltimore, Maryland 21215-0036

attending physician for use as the buria

funeral

Certification: To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A filled in by the Medical

Examine Physician/Medical

State Registrar

	leading in death) East	d.	
) order in more	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery  Month Day Year
	•	ontributing to death but not resulting in the underlying cause given in Part I.  RUCTIVE PULMONARY DISEASE	23e. Did tobacco use contribute to the cause of death?  1 🕱 Yes 2 🗆 No 3 🗀 Probably 4 🗀 Unknown
			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 2
	25. Was case referred to medical	26. Place of Death (	Check only one)
2	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1   Inpatient 2   SER/Outpatient 3   DOA   Other: 4   Nursing Home	e 5 Residence 6 Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  8c. Injury at Work?  1  Yes 2 No	d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	6f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D15452

OSLER DRIVE. TOWSON.

29d. Date signed (Month, Day, Year)

MARYLAND

RESSENT

2 Medical E

and manner stated.

7601

32 Registrar's Signature

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print)

M. D

29a. Certifier

29b. Signature and title of certifier

TIMOTHY

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #17&18&19a&b Per ANA BD C789 5/23/08 IH
Registrar

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30 2008 George R. Butler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 19, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☑ M 2 ☐ F 84 Director 219-16-6877 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Maxical Examinar must be politiced at 1 ∐ Yes 2 √∏ No Director MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5412 Old Court Road 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Does 2 No If Yes, Give Year or Dates: 143-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mailman <u>Postal Service</u> 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Elisha Butler Otelia Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Northwest Hospital Hospice
Thelma E. Butler /spouse
20a. Method of Disposition 5401 Old Court Road Randallstown, MD 3Cuimpor #2B
20b. Place of Disposition (Name of cemetery, crematory or other place)

Pikesville, MD 21208
20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify 21. Signature of Funeral Struce Li State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mutiple
Due to (or as a consequence of): **Physician** Myoloma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 □Yes 2 TNo 2 🗆 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After 5 Pending investigation 1 W Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1445931 May 14th 2008 nysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 MAIN Street Reisterstrum MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland.  1 - State Registrar	Department of Health  Certificate of Deat		tal Hygie Reg.	2000	16661
	Æ,		Decedent's Name (First, Middle, Last)		2. 🗆	ate of Death		3. Time of Death
- 0	Physicia		Bennie Battle		107	Month	Day Year	6:10 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death		4c. County of Death	
			Doctors Community Hospital	Lanham			Prince Ge	orge's
	Funeral Director		5. Social Security Number unk 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last	birthday) If Under 1 Year If Under 1 Year Months Days Hour	der 24 Hrs. 8. D	ate of Birth Month, Day, Ye J 19, 1	9. Birthp Cour 964 Washi	lace (State or Foreign atry) ngton DC
	-44		Usual Residence of Decedent		410	v 10, 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	yland now at		10a. State 10b. County 10c. City, T	own or Location			1	0d. Inside City Limits
	a-f sh	ż	MD Prince George's Lan	dover				1 □ Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wi	je L	2436 Kent Village Drive	20785	5		USA	
	e ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mexi</li> </ol>	Origin? (Specify ican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Americ Black, White,	
36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Fi	1 ☐ Yes  1 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No Spec	cify:		Specify: b1	ack
4772 E 21215-0036	hour tural	q pa		6a. Decedent's Usual Occupation		unk 168	b. Kind of Business/In	dustry unk
15	in 72	olete	(Specify only highest grade completed)	(Give kind of work done during n life. DO NOT use retired)	most of working		o, rand or baomesorm	oddity
212	iene. thar	mo	Elementary/Secondary (0-12) College (1-4or 5+) unk unk					
D	other rent,	e C	17. Father's Name (First, Middle, Last)	18. Mc	other's Name (Fire	st, Middle, Mai	iden Surname)	
$\varepsilon$ ylar	Menta Menta arked atic ev	To Be Completed	Bennie C. Battle Sr	F1	orence B	raxton		
$E_{N,0} \in \mathcal{L}$ e, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	)	19a. Informant's Name/Relationship (Type. Print) Ellen Walker/sister	19b. Mailing Address <i>(Street and Nur</i> 2436 Kent Villag	mber or Rural Ro ge Drive	ute Number, C. Landove	ity or Town, State, Ziper,MD 20	785
$\sum_{\mathcal{E}_{i}}$	f Heal		com	e of Disposition (Name of etery, crematory or other place)	Date	200	c. Location - City or To	own, State
7 J	Page ient o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) In State	etery, crematory or other place;	1			
$ec{eta}_{\mathcal{E}_{\prime}}$ Baltimore,	rmit. spartm porta y inju		21. Signature of Euneral Service Licensee Ronard Swade, Dix/2007	22 Name and Address of Fa State Anatomy	v Board (	555 W.	Baltimore	Street
<u> </u>	89 2 2 2		Strassille	Baltimore, MI	$D_{-21201}$		_	
10	Estate .		3a. Pa 1. Enter the disease, or complications that caused the death. I should, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such	as cardiac or res	piratory arrest,	,	Approximate Interval Between Onset and Death
	Physician		Immediate cuse (Final disease or condition resulting in death)	DEATH				Onset and Death
	/Medical Examiner		Due to (or as a consequer	ce of):	ilea.	11 1 1	0.1	
	_ 50, 8	<u>-</u>	Sequentially list conditions, if any leading to immediate Due to (or as a consequent	ENTORIAL ce of): RIGHT CE	HEKV	A	101	
	nsit	Examiner	Esquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	RIGHT CF	05 Q01	181	ENDOT	
Ć,	ficate be executed physician and s the burial-transit	Exa	resulting in death) Last  C. Due to (or as a consequent	ce of):	KEDINA		Marc.	
68760,	e be sicial e buri	edical	d					
89		edi						
. Box	h cer endin use	S I	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de				23d. Date of deliv	*
O. B	ires that the death certil signed by the attending d be detached for use a	Physician/M	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  9 □ Unknown				Month	Day Year
Э.	d by letach	Phy	Part II. Other significant conditions contributing to death but not resulting	o in the underlying cause given in Pa	art I	23e Did tohac	co use contribute to t	he cause of death?
ds,	signe signe	by	DIABETIC KETOACI		uit i.		2 No 3 Proi	1
Ö	w requir been si should	etec				04- 144		
Rec	has ge 2 s	Completed	METABOLIC DERRA	NGEMENT		24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
<u> </u>	n: The		25. Was case referred to medical			1  Yes 2		2 No
⋚	Physician: The this certificate al director, pag	Be	examiner?	Othor	lace of Death (Ch		e 6 Other (Special	E.A.
o	g Phy er this eral d	2	27. Manner of Death 28a. Date of Injury 28	8b. Time of 28c. Injury at			injury occurred	у)
ion	nding th. r: Afte	tio	1 DNatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work? M 1 ☐ Yes 2	2 □ No			
Division or Vital Records, P.O	Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office		ocation (Stree	et and Number or Rura State)	al Route Number,
Ö	tal or is after all Dile	Cert						
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier  (Check only one)  One)  Certifying Physician: To the best of my knowle and manner stated, and manner stated.					
	Fo the vithin rough comple	ĕ	29b. Signature and title of certifier	29c. License numb	per	29d.	. Date signed (Month,	Day, Year)
	, ,,,,		I had com	D6159	52		5/8/0.	5
			30. Name and address of person who convieted cause of death (Item 23			-	, , , - ,	
			30. Name and address of person who completed cause of death (Item 2:  KEVIN EKFAN M. B. 8118 6)  31. Date filed (Namth Pag) Year) 7 118 82 Pegistrar's Signature.	rood fire RUAN	LANT	IM, M	100 706	
	Sta	to	31. Date filed (Nearth, Day) Year) 7 11 St. Registrar's Signatur	Arnete 2				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:29 PM M 2008 May 15, Victoria Baskin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Timonium If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | Min. | Mar 1, 19 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛛 F Yrs. 83 125-14-2152 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1√ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Hamill Court #37 21210 USA 'natural", or items 23a dical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 🗓 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hecht Company buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Rothman Sarah Fisch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hamill Court #37 Baltimore, MD 21210 Shari Baskin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 21. Signature of ROHALA State and Address of Sacret 655 W. Baltimore Street Þ Baltimore, MD 21201 22a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or contion resulting in dear) non-small coll Physician Due to (or as a consequence of): Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tral Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown of death? Completed by □Unknown s available Be pue ပ Certification: umber.

The law requires that the death certificate be executed Box 68760 Records, or Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: Aft

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

art II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did	tobacco us	se contribute to the cause of de
emphy sems				11	ryes 2□	] No 3 ☐ Probably 4 ☐ Ur
					opsy formed?	24b. Were autopsy findings average prior to completion of cate death? 1 □ Yes 2 □ No
5. Was case referred to medical		_	26. Place of Dea	th (Check only	one)	
examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing H	lome 5 ☐ Res	sidence 6	Sother (Specify) hospi
7. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specifical Control of the control of	ome, farm, street, factory)	ory, office	28f. Location City or To	(Street and own, State)	i Number or Rural Route Numb
29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)	ysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to th urred at the time	e cause(s) e, date and	and manner as stated. place, and due to the cause(s)
9h. Signature and tille of certifier		2	9c. License number		29d. Date	e signed (Month, Day, Year)

58303

Charles St Tom Son MP 21204

18 2008

MAY

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM 32. Registrar's Silmature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** BENICO 6:01A M MICHAEL 18 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Howard County General Hospital** Howard Columbia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□F Days Min Director PA 146-01-1602 Nov 6, 1915 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department of Health and Mental Hyglene in "Internati", or Items 23a or 28a-f sho Important; If Item 27 Is marked of ther than "natural", or Items 23a or 28a-f sho any InJury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dayton Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21036 Funeral 4201 Linthicum Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give / Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 δ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Copper Refining Laborer 4Ω 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Matovcik John Benko 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2306 Bryan Park Ave. Richmond, VA 23228 John Benko 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) May 22, 2008 Richmond, VA Forest Lawn Cemetery 21. Signature of Funeral Se vice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death , or complications that ca ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** SEISIS 24 HKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician ed by the attending getached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2□No 1 Yes 2 ₹No 1 ☐ Yes To the Hospitai or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide within 24 hours a To the Funerai Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 75/860 MA

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

10700

CHORTER DRIVE #200

21044

Cours,A

ess of person who completed cause of death (Item 23a) (Type, Print)

FIS4

MO

32. Registrar's Signature

JONATHAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M State of M Registrar	aryland / Depa	artment of F	lealth and N Death	Re	iene 2008	16669
В	Physici	an	1. Decedent's Name (First, Middle, Last)  Rose Marie Corbett				2. Date of Death Month May 20	D, Day 2008 Year	3. Time of Death 5:39 pmm
>	/Medio		4a. Facility Name (If not institution, give street and number)  17 Cedarmere Rd.			r Location of Death	J	4c. County of Death Baltimo:	
Ē	Funeral Director		153-22-7267 1□M 2ÅF	ge (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 13	Year) 9. Birthp Cour 1930 New	place (State or Foreign otry) Jersey
	Maryland f show led at	jo	Usual Residence of Decedent  10a. State 10b. County  Md. Beltimore	10c. City, Town or Lo Owings M				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n with the l 3a or 28a- st be notif	al Director	10e. Street and Number 17 Cedarmere Rd.	I	10f. Zip Code 21117	7	10	Og. Citizen of What Cour	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Armed Forces' 1 □ Yes ② If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【XNo		pecify Yes or No- pecify Yes or No- No- No- No- No- No- No- No- No- No-	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	d within 72 ho giene. •r than "natui the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give	dent's Usual Occup kind of work done DO NOT use retired USEWITE	oation during most of work d)	king	16b. Kind of Business/In Homemak	·
Maryland	ould be file Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) William Aloysius Galla	agher			e (First, Middle, M Mary Ko	·	
, Mar	and 2 sho ealth and n 27 is ma ier trauma		19a. Informant's Name/Relationship (Type. Print) Gail Miller - Daughter	1660	Hosfeld	Dr., Wes	tminster	City or Town, State, Zip, Md. 21157	
Baltimore,	Pages 1 ment of H ant; If iten ury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Druid R	idge Cem.	May	24, 2008	20c. Location - City or To Pikesville	, Md.
Balt	permit. Depart Import any inj		21. Signature 15 Per Service Licensee	2	2. Name and Addre Eckhardt 11605 Rei	ss of Facility Funeral Isterstow	Chapel, in Rd., O	P.A. wings Mills	, Md. 21117
8760, ≪	The law requires that the death certificate be executed  At has been signed by the aftending physician and the action of the act	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events cause.	a consequence of):	_	ng, such as cardiac	or respiratory arre	SI,	Approximate Interval Between Onset and Death
P.O. Box 68	the death certifical / the aftending phi ched for use as th	Physician/Medical		2 Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of deliv Month	ery Day Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death I	out not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	paceo use contribute to t es 2 □ No 3 □ Pro	he cause of death? bably 4 □Unknown
Il Records,		Completed	,				24a. Was ai autops perforn 1∐ Yes 2	y prior to co	opsy findings available impletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes	ent 2 ☐ ER/Outpatie	nt 3□ DOA Oth		th (Check only one	e) ence 6 ⊟Other <i>(Speci</i>	fv)
ion or	Attending Physrdeath. ector: After this by the funeral di		27. Manner Death 1 Valural 5 □ Pending 2 □ Accident investigation 28a. Date of inj (Month, Discontinuous)	ury 28b. Time o Injury	of 28c. Inju- Wor	ry at rk?  Yes 2 □ No		w injury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building, e	jury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	reet and Number or Run n, State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1	of examination and/or in					
	To the vithin To the comple	Me	29b. Signature and title of certifier	_	29c. Licens	se number		9d. Date signed (Month,	
	12		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	buty circo		MO 919	VF1
ė	Sta Registi		31. Date filed (Month Pay, Year) 2008 Regist	7501	ules	1	WJON,	1,210 010	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deaft **Physician** COW HOY 5.10AM MAY 13 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last bilth 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Year -36 Months 1 □ M 2 1 F Days Hours 817 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 <u>^</u> Blace 4 Divorced 3 Widowed "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) years irst, Middle, Last) Be ss 1 and 2 should be first Health and Mental Hitem 27 Is marked ot 2 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number of Baltimore, 20a. Method of Disposition Pages ' permit. Pages Department of Important: If it any Injury or o to Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus C 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Inter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate for the following the sequence of injury Due to (or as a consequence of) certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 2 certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Tes 2 No 1 Inpatient ဂ္ 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: 5 ☐ Pending investigation or Attending Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Under the cause (s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated To the I 29b. Signature and title of certifier 29c. License number 29d. Date\_signed (Month, Day, Year) D28595 sullin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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State

TASNEEM

31. Date filed (Month, Day, Year)

SmITH

SUITE ZO3

2835

32. Registrar's Signature

LAKHANI

2 2 2008

MD 21289

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 Mar Eugene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore 'ollie 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, ) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 11 2M 2□ F 89 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show r than "natural", or items 23a or 28a-f shov the Modical Examiner must be notified at MD 1 □Yes 2 No Baltimore andallstown Director 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 €2 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Maricel Exami 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) General Electric College (1-4or 5+) Elementary/Secondary (0:12) Machinist 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) Be Ezekiel Clark Maria Charles ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia Martin Randalbtown MD 21133 38110 Collier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Owings Mills, MD 1 Burial 2 Cremation 3 Removal from State garrison 05/27/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugher C. Greene tuneral SVCS 8728 Liberty Road Randal Stown ND 21133 21. Signature of Funeral Service Licenses Ĉ. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MILURG Physician IRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BRONCHM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ULMONARY sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, PNEUMONIA Physician/Medical attending p for use as t 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗷 No 1 ☐Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 4 Homicide 🔀 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier 000614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEGHT AVE BALTIMORE, M'S ZIZIS

State Wegistrar

31. Date filed (Month, Day, Year) MAY 2 2 2008 2. Registrar's Signature

ORIGINAL

HIBGETY

DHMH 17 Rev 1/2001

08-03478 Paul L. Clark

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Cert	ifficate of Death	Reg.	No.	
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month D	av Year	3. Time of Death 2255 hrs
Acon Exami	mer	Paul L. Clark  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 6, 2008	4c. County of Death	
		2111 West Baltimore Street	Baltimore			
Funeral Director		5. Social Security Numberunk 6. Sex 1 N. Age (In yrs. last 1 N. M. 2 F. 56	Months Days Hours Min	8. Date of Birth (		thplace (State or unk untry)
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, T	Fown or Location	<del></del>		10d. Inside City Limits
and show nce.	ō	MD B:	altimore			1 X Yes 2 No
D 21215-0036 should be filted within 72 hours after death with the Maryland and Montal Hygiene 1 is marked other than "natural", or items 23a or 28a-f show ratic event, the Medical Examiner must be notified at once,	I Director	10e. Street and Number 2111 W. Baltimore Street	10f. Zip Code 21217	10g.	Citizen of What Cou USA	ntry?
r death wit	Funeral	1 Yes 2 No	nk If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	White, etc.	ican Indian, Black, black
urs afte tural" amine	d by	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 X No specify:  16a. Decedent's Usual Occupation (Give kind of v	vork don		
11215-0036 Id be filed within 72 hou fental Hygiene. narked other than "nai	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk	during most of working life. DO NOT use reti			- E
ID 21215-0036 should be filed within 7 and Mental Hygiene. ?7 is marked other than natic event, the Medica		17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	(First, Middle, Mai	den Surname)	unk
2121 ould be fill Mental I marked ic event,	To Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or F	Rural Route Numbe	er, City or Town, State	e, Zip Code)
MD and 2 sho alth and m 27 is	Ċ	O.C.M.E.	111 Penn Street Balt			
Baltimore, MD 21 permit. Pages and 2 should Department off Health and Me Important: If item 27 is ana injury or other traumatic er		1 Burial 2 Cremation 3 Removal from State	lace of Disposition (Name of cemetery, ematory or other place)	Date 2	Oc. Location - City or	Town, State
Balt permit. Departi Importi		21. Signature of Funeral Service Licensee Romald S. Wady, Director	22 Name and Address of Facility State Anatomy Board Baltimore, MD 2120	d 655 W.	Baltimore	Street
Physician /Medical	,	23a. Par 1. Enter the disea / , or or melications that caused the death. I fail re. List only one ruse on each line.		r respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiova  Due to (or as a consequence of)				Death
	_	Sequentially list conditions, b				
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ted Insit	Exar	events resulting in death) Last Due to (or as a consequence of)				
Sox 68760, death certificate be executed e attending physician and for use as the burial - transit	Medical Examiner	d.		- <u> </u>		
760, icate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of deliver	·
ords, P.O. Box 687 w requires that the death certific is been signed by the attending should be detached for use as it	Physician/	past 12 months?  4 Pregnant at time of dear	2 Fetal death 3 Ectopic pregna th 5 Other (Specify)	incy	Month	Day Year
Bone deat	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
P.O.	by	Part II. Other significant conditions contributing to death but not res Diabete Mellitus	sulting in the underlying cause given in Part I.		2 No 3 Pro	the cause of death?
ds, equire een sig ould be	Completed	Chronic Alcoholism		24a. Was an	24b. Were a	utopsy findings available
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	mp			autopsy	ed? death?	completion of cause of
ALRA	Be Co	25. Was case referred to medical	26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Y	es 2 No
Vita	To B	1 V 1 es 2 140	ER/Outpatient 3 DOA Other Nursin	ng Home 5 Re	esidence 6 🗸 Othe	er: Scene
		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how	v injury occurred	
iSiO	icati	2 Accident Investigation 28e Place of Injury - At hor	me, farm, street, factory, office building, etc.	28f. Location (Stre	eet and Number or R	ural Route Number, City
Divis pital or A ours after or al Direc	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Stat		
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Fourral Director: After this certificate ha completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and and manner stated.				
F \$ F 5	ĭ	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mo	onth, Day, Year)
		my m, mo	O.C.M.E.		May 7, 2008	
		<ol> <li>Name and addréss of person who completed cause of death (Item 2 Ling Li, MD Assistant Medical Examiner 111 F</li> </ol>	<sup>23a)</sup> Penn Street, Baltimore, MD 21201			
St Regist		31. Date filed (Month, Day, Year) MAY 2 2 2008 32. Registrar's Signature				
					·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1. OSPM Emelie Rebecca Daniel May 18 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Ruxton of Pikesville Pikesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 3KF 85 13,1923 St. Vincent Director 580-27-7014 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show Baltimore 1√2¥es 2 □ No Director N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt 1H St. Vincent& 21218 1923 E. 34th Street Grenadines filed within 72 hours after death v Hygiene. other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 3 years marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiny or other traumatic event once. Manny Williams Violet Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type. Print) 1923 E. 34th Staget 1H Vistula Walcott/ Daughter Baltimore, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/31<sup>Date</sup>08 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Vincent&The Lowmans Windward Cem. 4 ☐ Donation 5 ☐ Other (Specify) Grenadines 22. Name and Address of Facility Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 Signature of Foperal Service Licens ern auro 23a. Par. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Caux (Final Physician ASEVD WHITDEMENTIA 104 Fm disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. I 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 【No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate SACRAL 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 21328 08 Jacobs

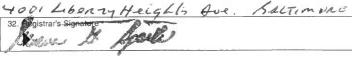
State

31. Date filed (Month, Day, Year) 22 2008 Registrar

Cosmo

JOCOBI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 K Day Physician 20 VAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner VA Medical Center + murp -mu Re 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours Min. 22-60-6938 Director New. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Bai Director 10e. Street and Number 10g. Citizen of What Country? 21071 U.S. A. 4501 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married if Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caulasion Specify: 3 Midowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rd. 12 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) onaldson eola 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or ictoria 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown tor: After this certificate has been signed by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Q Q 2 ☐ No Completed 24a Was an 1□ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier

21071 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Greene Stope 31. Date filed (Month. Day, Year) 32. Registrar's Signature MAY 22 **ORIGINAL** 

Terse

1 ☐ Yes 2 No

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11.13 2008 HELEN FITZHUGH 1A' /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY TIMORE HOSPITAL BAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1□ M 2 □ F Months Days Hours 217-20-632 Director ·1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Interportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Executant roust for rediffied at once. 1 Hres 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2. Was Deceded Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 1 No Š Jack 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) riva 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fitzh Eartha 1025 Wither Spoon Ad Baltimore MD 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/2008 Baltimore, MU 4 ☐ Donation 5 ☐ Other (Specify) Vaughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MI Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injurthat initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: 1 ⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 C-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie FES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL BACTIM JEE no 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 22 2008 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Joan Catherine Fisher May 16 2008 12:25P. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Hospice Dove House Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F 214-22-3640 5/21/1926 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Y Yes 2 No WESTMINSTER CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1169 LONG VALLEY RD. 21158 USA Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING BOOKKEEPER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LILLEY CHRISTINA McCARTY HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BRUCE FISHER - SON 1169 LONG VALLEY RD., WESTMINSTER, MD 21158 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 5/19/08 W Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD BALTIMORE NATIONAL CEM. 4☐Donation 5 ☐Other (Specify) 21. Signatu For Puperal Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Fraholisus immediate Cause (Final

**Physician** /Medical Examiner

Department of H Important: If Ite any injury or ot

s 1 and 2 of Health a Item 27 Is

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Pedical Evantion of the the Pedical Evantion

within 72 hours after

Baltimore, Maryland 21215-0036

Medical Certification; To Be Completed by Physician/Medical Examiner signed by the attending physician and I be detached for use as the burial-transi within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

disease or condition	a. TUINIONAVO CONSTITUTO	77	1 week
resulting in death)	Due to (or as a consequence of): Severe Pulmonary Ho	pertension	5 years
Eaguernially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
that initiated events resulting in death) Last	C. Due to (or as a consequence of): d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 9 Unknown	23d. Date of a	delivery Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	**
		performed? death	autopsy findings available to completion of cause of 1? res 2 16
25. Was case referred to medical	26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing H	lome 5 ☐ Residence 6 ☐ Other (S	ipecify) Dive tous
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury  M  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury occurred	
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,

1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 7 5 20 3 5

Westminsta

29d. Date signed (Month, Day, Year)

MD 21157

2008

State Registrar 31. Date filed (Month, Day, Year)

CHACICO

29b. Signature and title of certifier

29a. Certifier

Stoner 32 Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month GRELL TER MUY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Baltimore 8011 Wynbrook Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1**X** M 2□ F Months 220-18-8650 81 January 15, 1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 **USA** 8011 Wynbrook Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Continental Can Co. Tow Motor Operator 9 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carmela Papa Guido Grelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8011 Wynbrook Road, Baltimore, Maryland 21224 Wife Lorraine Grelli 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State May23,2008 Rosedale, Maryland Cardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 e or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, lift only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) COLON CHNOER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. From the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 30 No 1□ Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760, as t attending p signed by the a P.0. or Vital Records, has le 2 page this certificate To the Hospital or Attending Physician: Division

Physician /Medical

Examiner Physician/Medical Completed by Be P To the riospose.

Within 24 hours after death.

To the Funeral Director: After th funeral Certification:

Physician

/Medical

Directo

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exminer must be notified at

State

Registrar

Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

062032

I Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

SOSHOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

ENNIFER 31. Date filed (Month, Day, Year)

MAY 2 2 2008

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State Regis	Amend	19a & 2	Sta Ob, perI	te of Ma NF G879	ryland / 1 5/27/08	Depar Terti	tment of F ificate of	lealth ar <i>Death</i>	nd Men	tal Hyg	iene	008	166	78
3.	1. Decede	nt's Name	(First, Middle							2. [	ate of Deat	h	Voor	3. Time of	Death
Physician /Medical	( 1 /	ARY						Godse	Y	N	Month I A Y	2 l	2008	061.	2 M
Examiner		Name (If I		, give street a	nd number) Hosy	12+1	4	4b. City, Town, c		Death	Y	4c. Co	ounty of Dea	ith	
Euporal	The 5. Social S	Security Nu		opkins 6. Sex	*	(In yrs. last bi		Baltim If Under 1 Year	If Under 24	Hrs. 8 E	ate of Birth		9. B <u>i</u> r	thplace (State of	r Foreign
Funeral Director		-24-88		1□M 2[	X	34	Yrs.	Months Days	Hours		Month, Day, G. 28			VA	
pu »	Usual Res	sidence of D	Decedent 10b. County		, , ,	10c. City, Tov	n or Loca	tion						10d. Inside Cit	v I imits
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th with sith sith sit		KENT	TUCKY	AVENUE				21213	3			US	SA		
fter death v r items 23a iner must	11. Marita			Arm	s Decedent E ned Forces?		13. Wa	as Decedent of h res, specify Cub	lispanic Originan, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	14	. Race - Am Black, Whi	erican Indian, te, etc.	
J36  Jrs afte  al', or if  xamin			ed 2□ Marr 1□Divorced	ied 1 T	]Yes <b>24</b> ☐ N es, Give ar or Dates:	0	10	Yes No	Specify:			S	pecify: <b>BL</b>	ACK	
5-0036 72 hours af ratural", or dical Exami			15. Deceden	t's Education		168		nt's Usual Occup		-		16b. Kind	of Business	/Industry	
Z1Z15-00 ed within 72 hou ygiene. ner than "natura t, the Medical E	Elemen		dary (0-12)	st grade comp	lege (1-4or 5-	+)	life. DC	nd of work done NOT use retire	d) most o	or working					
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E aga a	i	`	GODSE	,						SIVAINE (FIII	MIN		imame)		
Maryla d 2 should   th and Men th and Men traumatic traumatic				hip (Type. Prir	nt)	19	b. Mailing	Address (Street					own, State,	Zip Code)	
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or Healt of Healt of Healt or other	20a. Meth	od of Dispo	osition	3 □Remova		20b. Place of	of Disposit	tion (Name of ntory or other pla	ce)	Date	-	20c. Loca	tion - City o	r Town, State	
Pag ment ment lant: I	4 🗓 €	Onation !	5 Other (S	pecify)	I IIOIII State	Stoop		ALS CEMET	CKI	-27-0			MORE,		
Baltimore, permit. Pages 1 a Department of Her Important: If Item any Injury or othe once.	21. Signa	fure of Fun	peral Service	Licensee	711 -	0								NS F.H.	, INC
	23a. Pur	1. Enter th	e disease, or	complications	that coused	the death. Do		the mode of dyi					.121/	Approximate	9
Physician	shè- Immediat	<b>c</b> k, or heart te Cause (F	t failure. List inal	only one caus	e on each line	e. 17 thmi					,	,		Interval Bet Onset and I	Death
Physician /Medical	disease of resulting	or condition in death)		a		consequence								50 MI	'nutes_
Examiner	0	allo that area	NA	h	Coron			7 D	iseas e	>				10 70	curs
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Hecords, P.O. Box of The law requires that the death certif te has been signed by the attending age 2 should be detached for use as completed by Physician/Me	IF FEMAI 23b. Was	decedent		23c. If y	es, outcome p	of pregnancy 2 □ Fetal deat	h 3∏F	ctopic pregnanc	ev.			23	d. Date of de		
e deal be deal he att	in th	e past 12 r Yes 2		4	Pregnant at			Other (specify) _					Month	Day `	Year
P.O. hat the d by the letache	Part II Ot	Unknown her signific	cant condition	nns contributio	ng to death bu	ıt not resulting	in the und	erlying cause gi	ven in Part I		23e. Did to	bacco use	e contribute	to the cause of c	leath?
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w required shoul											24a. Was a	ın T	24b. Were a	autopsy findings	available
VITAI HECOTICS, stelan: The law requires t certificate has been signe rector, page 2 should be of											autops perfor 1☐ Yes	sy męd?	prior to death?	completion of c	ause of
		case referre	ed to medica	ı					26. Place o	of Death <i>(Cl</i>			7,10		
Of V Physic	1)X(Y	es 2□N		Hospital	1 🔲 Inpatier			3 DOA					□Other (Sp	ecify)	
on or VIta ding Physician:  After this certific funeral director,		er of Death latural	5 Pendir	g	. Date of Injur (Month, Day		Time of Injury	28c. Inju			Describe h	ow injury	occurred		
JIVISION I or Attending after death. Director: Afte I in by the fune	2□ A 3□ S	2 Accident investigation 3 Suicide 6 Could not be 280 Block of injury. At home form st						M 1 Yes 2 No			of. Location (Street and Number or Rural Route Number,				
DIVISION C ital or Attending F its after death. ral Director: After led in by the funera Certification:	4 🗆 F	lomicide	determ	ined	building, etc	. (Specify)	,	,			City or Tow				,
		eck only						occurred at the testigation, in my						as stated. ue to the cause(s	s)
the Hosp thin 24 hou the Fune ompletely fil	29h Sign	*)	title of certifie	an	d manner sta				se number					nth, Day, Year)	
Too		sesse			ical	Doctor	-		- 000	)				2008	
5	30. Name			who complete	d cause of de	ath /Itam 22a	(Type P	nint) North h	Solfe S	Strept	BOLF			land 21	287
State	04 - D-4-		4	, ,	Registra	ar's Signature	1	w.	-1/( )	1.661	,		, (		/
Registrar		M	AY 22	2008	Of the	, St.	1384								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6 bert green 18 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, gi street and number) Baltimas Bal 1403 timore If Under 1 Year | If Under 24 Hrs. Nate of Birth (Month, Day, Year) 8-2-1945 Birthplace (State or Foreign Country) Days Min M 2□F Usuai Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Biack, White, etc. 1 Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) ive kind of work done during most of working e. DO NOT use realized) Caffe ae (1-4or 5+) Elementary/Secondary (0-12) **XYYS** r's Name (First, Middle, Last) 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other ( 3 ☐Removal from State 5 Cther (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 ni ardiac Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIV/MDS 4 Unknown 2 No 3 ☐ Probably

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

a or

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must bonce.

Baltimore, Maryland 21215-0036

**Funeral Director** 

Be Completed by

Examine Physician/Medical the by Be Completed Certification: To within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

						24a. Was an autopsy performed  1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No			
5. Was case referred to medi-	cat	26. Place of Death Check onlone								
examiner? 1 ☐ Yes 2 ☑ No	Hospita	ll: 1 ☐ Inpatient 2 [ •	ER/Outpatient	3 🗌	DOA Other: 4 Nursing	g Home 5 Residence 6	autopsy prior to completion of cause of death? Yes 2 1 No onl one    Residence 6 Other (Specify) cribe how injury occurred  tion (Street and Number or Rural Route Number,			
7. Maxier of Death  1. Natural 5 Pend 2 Accident inves		. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?	28d. Describe how injury	occurred			
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, Stafe)				

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2008

32. egistrar's Signature

29d. Date signed (Month, Day, Year)

18 000 8

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	ate of Maryland		tment of H <i>ificate of L</i>			giene Reg. No.	08	16680		
Q .		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death		
Physic /Medi	cal	Kenneth E	GLa.				MAY	8	2008	1:00 P M		
Examir	ner	4a. Facility Name (If not institution, give street			4b. City, Town, or		eath		inty of Death			
		Riverview Rehabilit	ation-HEALth (	center	If Under 1 Year	5 eX If Under 24 h	Hrs. 8. Date of Bio		-Tim	place (State or Foreign		
Funeral Director		5. Social Security Number 6. Sex 1以 M	7. Age (In yrs. las 2 F 85	Yrs.	Months Days		Sept 1	2, 192	2 Penr	nsylvania		
pu >		Usual Residence of Decedent  10a, State 10b, County	10c. City. 1	Town or Loca	ution					10d. Inside City Limits		
shov	5	MD Baltimore		Ess						1 ☐ Yes 2 ☑ No		
the N	ect	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?		
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked othar than "natural", or items 23e or 28e-f show othar treumatic avent. It we Medical Examinatings to multipled at	Ö	1 Eastern Blvd			21	1221		US	Α			
	by Funeral Director	1 Never Married 2 Married	Vas Decedent Ever in U.S. Immed Forces? ☐Yes 2 No f Yes, Give fear or Dates:		as Decedent of H Yes, specify Cuba		? (Specify Yes or Nuerto Rican, etc.)		Race - Amer Black, White ecify: wh:	, etc.		
2 hou	ted	15. Decedent's Education	unk unk	16b. Kind	. Kind of Business/Industry							
within 72 ene. than "na the Medis	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							rsonne	e1		
filed wit Hygiene thar the	Son	12	5+					Maridae Co	4-ide-Common			
be filed tal Hygie d other avent.	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle					
ages 1 and 2 should be nt of Health and Mental :: If itam 27 Is marked or othar treumatic av	2	Dana Cecil Glaze	n.:-a	40h Mailine	Address (Ctroot		May Thomp			in Code)		
		19a. Informant's Name/Relationship (Type, I Riverview Rehab & He					ssex, MD	21221		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
		20a. Method of Disposition  1 Burial 2 Cremation 3 Remo  4 X Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other p				Date		Oc. Location - City or Town, State			
permit. Pages Department of H Importent: If its any injury or of		21. Signature Funeral Service Lice see	Le fortence	Sta Ba	Name and Addre ate Anat ltimore,	ss of Facility Omy Boa MD 2.1	ard 655 W	. Balt:	imore	Street		
Pnysician /Medical Examiner		23a. Part I. Enter the disease, or complicative shock or heart failure. List only one call immediate Qause (Final disease or candition resulting in death)	ause on each line.	e.me	, .	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death		
icate be executed physician and s the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.											
he death certifics the attending pl thed for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year								
or Attanding Physician: The law requires that the death certificate death.  Director: After this certificate has been signed by the attending in by the funeral director. page 2 should be detached for use as	b	Part II. Other significant conditions contrib		3e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkn								
	Completed	Adrial F	24a. We auf per 1 🗆 Yes	opsy formed?	med? prior to completion of cause of death?							
	Be	25. Was case referred to medical examiner?	nital:		011	-	Death Check on					
	2	1 Yes 2 No   No   1   Inpatient 2   ER/Outpatient 3   DOA   One   Investigation   See   Residence 6   Other (Specify)										
	lon:											
I or Attanding after death. Director: After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Hospita 4 hours Funeral	edical Ce											
To the within 2 To the complet	Me	29b. Signature and title of certifier	VO 1/4			se number		29d. Date	signed (Mont	th, Day, Year)		
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		30. Name and address of person the comp	wh 11	24	Mac	2 Hru	e, Bab	to, 1	40.	21221		
S Regis	tate trar	31. Date filed (Month, Day, Year) MAY 2 2 2008	32. Registrar's Signati	ure Con								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:38 A<sup>M</sup> **Betty Resh Gitt** May 14, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Catonsville **Charlestown Care Center** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1□M 28 F Months Hours 75 Jun 12, 1932 Director 215-31-9863 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Catonsville Director **Baltimore** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 U.S.A 709 Maiden Choice Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Tyes Specify: White ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Louise Lucas George Daniel Resh Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5228 N. Pennsylvania St. Indianapolis, IN 46220 Deborah Gitt Stoll 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 15, 2008 Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) All County Cremation Services, 22. Name and Address of Facility Service Licensee 21. Signature of Funera Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Men /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 4□Pregnant at time of death the 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 Ho 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Other: Hospital: 4 Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death.

To the Funeral Director: A the Hospital completely

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). aus 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1155 PM **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center 13altimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Hours Months Min. 1**X**) M 2□ F 82 March 20, 1926 Maryland 218-16-1429 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Directo Maryland N/A **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6226 Brown Avenue 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) United States Military Tech Sergeant <u>12 years</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Urbanski Walter John Hisley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6226 Brown Avenue, Baltimore, Maryland 21224 wife Alice Hisley Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery May 24,2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Cornelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, o shock, or heart failure. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death complications that caused the death, only one cause on each line. Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duri to for as a consequence of The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month in the past 12 months? Day ed by the ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy autops, performed? Yes 2 No 25. Was case refe d to medical examiner? 1 ran 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death Check onl one Be Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Bran Silverman . 4940 Ecustern Am 4940 Eastern Avenue, Baltimore, Maryland 31. Date filed (Month, Day, Year) Registrar 2008

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

STEVEN AXE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

7601

32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

29c. License number

D34543

OSLER DRIVE TOWSON. MARYLAND 21204

29d. Date signed (Month, Day, Year)

08

Baltimore, Maryland 21215-0036

1 - For State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAY 2 2 2008

SOMA

**Physician** /Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be rutified at once.

**Physician** /Medical

Examiner

Be Completed by Physician/Medical

Medical Certification: To

To Be Completed by Funeral Director

Registrar		Certificate of Death	Mental Hygiene Reg. No. 200	2 6681
Decement's Name (First, Middle, Last,	HolliF		2. Date of Death Month Day Year MAY 8 2008	7. 1 1 / /3 M
Facility Name (If not institution, give	street and number) AL OF BALT	4b. City, Town, or Location of Death		
Social Security Number 6. Second 15				rthplace (State or Foreign
Ial Residence of Decedent . State 10b. County	1 199 City, To	whor Location		10d. Inside City Limits 1 ✓ Yes 2 ☐ No
Street and Number	Rd DAIL	10f. Zip Code	10g. Citizen of What Co	
Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	Pecify Yes or No- 14. Race - Ame	
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert  1 □ Yes 2 ☑ No Specify:	o Rican, etc.) Black, Whit	B/ACK
15. Decedent's Edu (Specify only highest grad		6a. Decedent's Usual Occupation (Give kind of work done during most of wor ke, po NOTuse retired)	king BAHM	of Oth
Father's Name (First, Middle, Last)	N-H T	17/1/ OUPCL VISUL	me (First, Middle Maiden Syrname)	au j
Mecou Holli	6	MAKUL	t KODERES	Zie O- / :
Informant's Name/Relationship (7)	(WHE) &	9b. Mailing Address (Street and Number or Ru	Date 20c, Location - City of	01204
Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	e of Disposition (Name of night stems of the party of the	70-08 MINAMAS 1	11/6. Ma.
Signature of Funeral Service Licens	A	22. Name and Address of Facility	SEPHO KUELS	IR 1 Ilm
7 01	X VVVIIIVU	USDIN, LENTER	YI'AVE, RAPITO, 1	VID 3/202
shock, or heart failure. List only o mediate Cause (Final ease or condition	ne cause on each line.	oo not enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
shock, or heart failure. List only o nediate Cause (Final ease or condition	lications that caused the death. Do ne cause on each line.  a. STAGO  Due to (or as a consequence)	E LUNG CANCE		Interval Between Onset and Death
shock, or heart failure. List only on the state of the st	a. <u>END</u> STAGE	E LUNG CANCE		Interval Between Onset and Death
shock, for heart failure. List only onediate Cause (Final base or condition ulting in death)  uentially list conditions, the list of the conditions of the c	a. STAGO  Due to (or as a consequence)	E LUNG, CANCE		Interval Between Onset and Death
a. Part1. Enter the disease, or complishock, or heart failure. List only of mediate Cause (Final lease or condition sulting in death)  quentially list conditions, ny, leading to immediate use. Enter to indentying use (Disease or Injury t initiated events ulting in death) Last	a. CND STAGE  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	E LUNG, CANCE		Interval Between Onset and Death
shock, or heart failure. List only of mediate Cause (Final base or condition ulting in death)  quentially list conditions, ny, leading to immediate ise. Either Uniceniying ise. Either Uniceniying ise (Disease or injury trinitiated events ulting in death) Last	a. CND STAGE  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ce of):  ce of):  cath 3   Ectopic pregnancy		Initerval Between Onset and Death
shock, for heart failure. List only onediate Cause (Final sase or condition ulting in death)  juentially list conditions, hy, leading to immediate se. Enter Universitying se (Disease or injury initiated events ulting in death) Last  EMALE:  . Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	Due to (or as a consequence to	ce of):  ce of):  ath 3 Ectopic pregnancy	23d. Date of de Month  23e. Did tobacco use contribute	Initerval Between Onset and Death  ACONTHS  Tellivery  Day  Year
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29d. Date signed (Month, Day, Year)

2008

MAY 18

BALTIMORE

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

State

MS

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SENGUPTA

29c. License number

SIMI HOSPITAL OF

RES OUT

08-03617 Gregory Ingram

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		For State	Certificate of Death		g. No.	
Physician/ Medical Examine	/	Pecedent's Name (First, Middle,Last)	Tharam	2. Date of Death Month May 11, 20	Day Year	3. Time of Death 1742 hrs
		4a. Facility Name (if not institution, give street and num			4c. County of Death	
	Ļ	3707 West Franklin Street	Baltimore Life Land at Vers 1/4 Land	or Odlice 10. Date of Birth	NA h(MM/DD/YYYY) 9. Birth	place (State or
Funeral Director	ć	5. Social Security Number 6. Sex 12 M 2 F	Age (In yrs. last birthday)  Yrs.   If Under 1 Year   If Under 1 Y		Foreign	
any	-	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
land f show		MD NIA	Baltimore			1 Yes 2 No
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Finneral Director		3707 W. Franklin	St. 21229	Ĺ	g. Citizen of What Count	
er death with t , or items 23s r must be not	Luileia	Never Married 2 Married Armed For	2 No	n, Puerto Rican, etc.)	14. Race - America White, etc.	an Indian, Black,
urs afte tural",	⋧┝	<ul> <li>Widowed 4 Divorced If Yes, Give Year or Dates:</li> <li>15. Decedent's Education (Specify only highest grade)</li> </ul>		kind of work done	Specify: G (a) 16b. Kind of Business/In	dustry
5-0036 ed within 72 hour lyglene. other than "natu the Medical Exar	andu	Elementary/Secondary (0-12) College (1-	A Laborer		Temp. Ac	gency
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)	i A	r's Name (First, Middle, M		
tould be find Mental I is marked tice event,		19a, Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Nur	mber or Rural Route Num	ber, City or Town, State,	
MD d 2 sho	1	<u> Elaine Stovall - Sister</u>	102 Summer C		11, MD 2/20	
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal fro  4 Donoron 5 Other Specify:	m State 20b. Place of Disposition (Name of cemetery, crematory or other place)  M. Carmel Cemetery	5-19-08	20c. Location - City or T Dundalk,	
Baltir permit. I Departme Importa		21. Signature of Fune al Service Licensee	22. Name and Address of Faciliti		NILTON YOUS	21229 I.M.D.
Physician	1	23a Part I Enter the disease, or complications that ca	used the death. Do not enter the mode of dying, such as o	cardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
'Medical aminer		The state of the s	munodeficiency Syndrome (AIDS)			Death
		Sequentially list conditions, b.	onsequence of):			
<del></del> ;		cause. Enter Underlying Cause (Disease or injury that initiated	consequence of):			
outed nd transit		events resulting in death) Last Due to (or as a d.				
760, frame be executed transit the burial - transit		UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Coefficial Coefficial Coefficial Expenditual Expensive and the funeral director, page 2 should by Divisional Madical Expensive and the funeral director and the funeral directo	Sicially	23b. Was decedent pregnant in the past 12 months?	nt at time of death 5 Other (Specify)	ic pregnancy	23d. Date of delivery Month Da	ay Year
O, B at the de d by the tached i	£		death but not resulting in the underlying cause given in P	art I. 23e. Did to	bacco use contribute to ti	he cause of death?
S, P.	o pe				2 No 3 Proba	,
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as indicated.	Completed			24a. Was a autop: perfor	sy prior to co	opsy findings available ompletion of cause of
ician: s certifi rector,	e n	25. Was case referred to medical examiner?	26.Place of Death patient 2 ER/Outpatient 3 DOA Other;	(Check only one)  Nursing Home 5	Residence 6 🗸 Other:	Scane
on of V nding Phys tth. r: After thi ne funeral di		27. Manner of Death 28a. Date of		k? 28d. Describe h	now injury occurred	Oscile
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the J	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	of Injury - At home, farm, street, factory, office building, e	etc. 28f. Location (S or Town, S	Street and Number or Rur tate)	al Route Number, City
the Hospi thin 24 hou the Funca	Medical	29a. Certifier (Check only one) 2	of my knowledge, death occurred at the time, date and plifexamination and/or investigation, in my opinion, death o			
5 4 8 4 8 5	E -	29b. Signature and title of certifier	29c. License number	OCME	29d. Date signed (Mon	th, Day, Year)
		Modern W. W. 30. Name and address of person who completed caus			May 19, 2008	
4			nt Medical Examiner 111 Penn Street, Ba gistrar's Signature	aitimore, MD 21201		
Stat Registra	~	MAY 2 2 2008	and to fresh			
DHMH 17 Rev 1/200	1		ORIGINAL			

		For State Registrar	State of Ma	aryland		rtment of F <i>tificate of I</i>	lealth and M D <i>eath</i>		giene Reg. No. 200	8 16685
		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	Day Ye	3. Time of Death
Physici /Medio		Gordon Phil:	lip Johnson	Sr.				May 20	, 2008	5:00 A M
Examir		4a. Facility Name (If not institution,					Location of Death		4c. County of D	
<u></u>		Gilchrist Hosp: 5. Social Security Number 6		e (In yrs. las	t hirthday)	Tows		8. Date of Birtl		
Funeral Director		220–14–3667	1 M 2 □ F	85	Yrs.	Months Days	Hours Min.	Dec. 3	1, 1922	Birthplace (State or Foreign Country) Maryland
and		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation				10d. Inside City Limits
Maryli I sho	tor	MD Balti	more	Ow	ings	Mills				1 □Yes 2 ANo
h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?
th wit		42 N. Ritters	Lane				1117		U.S.A	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Medical Examinar must be rediffed at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 MYes 2 1 If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba I□Yes 2ሺNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Race - 7 Black, V Specify:	American Indian, White, etc. White
nin 72 hou e. In "natura Medicel E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5		(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of work	king	16b. Kind of Busin	ess/Industry
d with giene ger tha	E C	6			Flo	or Finis			Floo	ring
be file	Be	17. Father's Name (First, Middle, L.						e (First, Middle, erie Ger	Maiden Surname)	
2 should be and Mental is marked or raumatic ev	ပ္	George Johns 19a. Informant's Name/Relationsh			10b Mailir	og Addross (Street			er, City or Town, Sta	ate Zin Code)
T, wan yearing 2 1 Z 1 and 2 should be filed with: Health and Mental Hygiene. em 27 is marked other than wher traumatic event, the M		Melvina Johns							lls, MD 2	
Pages 1 arment of Hee ant: If item ury or other		20a. Method of Disposition  1	ecify)	20b. Placent	petery, crer Park	sition (Name of natory or other place W Memoria	äl 5/2		20c. Location - Cit Sykesvil	le, MD
permit. Departr Importa	ki i	21. Signature of Funds Service I	1 - Marin		111	1605 Reis	terstown	Rd. Owi	ngs Mills	apel P.A. , MD 21117
Physician	8	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause in each li	the death. ne.		er the mode of dyi	_	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner			Due to or as	a conseque	nce of).					ments
ficate be executed for the physician and street burial-transit	Examiner	Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a linse ue	nce of):	Chyces				yens
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w requires that the dispersion signed by the should be detached	d by Phys	Part II. Other significant conditio	ns contributing to death b	out not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did t		ute to the cause of death?  Probably 4 Unknown
The law red ate has bee	Completed							24a. Was autop perfo 1 □Yes	psy prio prmed? dea	ore autopsy findings available or to completion of cause of ath?  Yes 2 □ No
ician: sertific	Be	25. Was case referred to medical examiner?	Hannital:			Lou	26. Place of Dea	th (Check only c		14/35/01/14
ing Physi After this c	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ury 2	R/Outpatie 28b. Time o Injury	f 28c. Inju	ry at	ome 5 Resi	dence 6 Other how injury occurred	(Specify) VOSPUC
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: T	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At hom tc. <i>(Specify)</i>	ne, farm, st	reet, factory, office	1163 2 110	28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
e Hospita 124 hours e Funera letely fille	Medical C	29a. Certifier (Check only one)  Certifying (2 Medical I	g Physician: To the best Examiner: On the basis and manner s	of examination	ledge, dea on and/or in	th occurred at the the threat	ime, date and place opinion, death occu	e, and due to the urred at the time,	e cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	Comb			29c. Licen	se number 5830	3	19d. Date signed (1	Month, Day, Year)
511	ľ.	30. Name and address of person	who completed cause of	death (Item :	23a) (Type	Print) N.C	harly s	is low	son my	21204
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2.2	2008 32. Regist	rar's Signatu	are Jan	SALL				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Colenea H. Johnson 1215 PM MAY 2008 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Balto if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M M X Director 239-40-3455 7.8 1-12-1930 N.C. Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1x Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 1563 Homestead Street 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner Black, White, etc. 1 □ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. Black Completed by 3 Widowed 4 ☐ Divorced 'natural", traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, Rosewood State Elementary/Secondary (0-12) College (1-4or 5+) llth grade <u>Assistance</u> Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone. is marked George Holman Goldie Bynum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherdenia Weaver-Daughter 213 Broat Street CarrBoro, N. C. 27510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 5-28-2008 Baltimore, MD 4 Donation 5 Other (Specify) Baltimore Nat 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H East Balto, MD 21202 1101 E. North Avenue Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** EKEBIKAL VASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4RDIAC MARKEST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): I Records, P.O. Box 68760,  $\mathcal{A}_{\mathcal{L}}$ The law requires that the death certificate be executed. and Due to (or as a consequence of) -burialphysician Physician/Medical YER FERATED PPRENDIC-1775 the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy page 2 No 1 Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending 1 Natural (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month. Day, Year) AT 2438946 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp MD KOBERT PLANNERY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** lones 7-2008 /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner Baltimure Baltimor 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1□M 2**Z**F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Windson Director 12 10g. Citizen of What Country? 10e Street and Number USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Hume maker 12years 17, Father's Name (First, Middle, Mother's Name (First, Middle, Maiden Surname) auss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 8 Emmanuel or other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State permit. Page Department o Important: If any injury or once, emelery 5-23-08 Woodawn, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vousnn C . Greene Zueal SNC. 21. Signature of Funeral Service Licensee M0401 23a. Part. Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLON CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 🗌 Yes 2∏No 2**X** No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE ပို 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760; WINIFRED JONES

1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

The law requires that the death certificate be executed attending pl s been signed by the should be detached certificate has b or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: Medical

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of cert

4 ☐ Homicide

29a. Certifier (Check only one)

29c. License number

TIMONIUM, MD 21093

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT 2300 DULANEY VALLEY RD.

and manner stated.

Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DNDA 20 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore Mercy Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 217-62-1651 1 M 2 F Jan. 2, OH 53 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a State 10h County 1xxYes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 429 George Street 21201 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 KNO 1 ☐ Yes 2/1X No Specify: Black 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 retail management K-Mart 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosalie Cager Oakley D. Jackson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lawrence D. McIntyre / Son 229 N. Linwood Avenue; Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 05/24/2008 Baltimore, Maryland Mount Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death

Month

1 ☐ Yes

POUL PL. SENTIMONE MD 2128

Day

24b. Were autopsy findings available prior to completion of cause of death?

2□No

Year

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-tran

the

use

for

detached

page 2 should

funeral director.

this

To the Hospin...
within 24 hours after death.
To the Funeral Director: Af

the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division or Vital

Immediate Cause (Final resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 ☐ Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, 22 2008

of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death ecedent's Name (First, Middle, Last) Month 05 Day 14 John Nathaniel Jordan 2008 7:20 A 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Baltimore Sinai Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 7, 1954 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours txXM 2□F MD 53 216-62-1727 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore txX Yes 2 ☐ No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 4615 Rokeby Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 XXNo Specify: à 3√EWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD Aviation Administration maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Burley Lula Carter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4615 Rokeby Road; Baltimore, Maryland 21229 Zeda Lockley / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 05/20/2008 Baltimore, Maryland Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licenses 21217 638 N. Gilmor Street; Baltimore, Maryand 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) ervical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Vialety that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 1□ Yes 2 No 2 No 25. Was case referred to medical examiner? Hos 1 ☐ Yes 2 🗖 No 6 □Other (Specify)

Examine siclan and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a signed t cate has been sig , page 2 should b director, After this funeral

after death

within 24 hours an To the Funeral C

the

filled in by

completely

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

Director

death with the Maryland

Physician/Medical þ Completed Be Certification: To 27. M

1/2

29a. Certifier

_			26. Place of Dea	ath Cl	heck onl one	
pital: 1 ☐ Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome	5 Residence	6 □Other
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d.	Describe how inju	ury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Manner of eath		28a. Date of Injury
1/X/Natural	5 Pending	(Month, Day
2 Accident	investigation	
3 ☐ Suicide	6 Could not be determined	28e. Place of injury
4 ☐ Homicide	determined	building, etc.

	IVI	112
28e. Place of injury - At home, farm, street, building, etc. (Specify)	factory,	office

	Work?	
M	1 ☐ Yes	2 🗌 No

28f. Loca	ation (Stre	eet and State)	Number	or Rural	Route	Number

(Check only one)	2☐ Medical Ex	aminer: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the ti	me, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	2	29c. License number	29d. Date signed (Month, Day, Year)

29c. License number

Drive, Surt

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIRPARA 31. Date filed (Month, Day, Year.

7505 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 16 hv 10 M Edward MAY 2008 William Kinsey, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAUTUNORE, MD, 21223

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Days Hours Min.

MAY 7 1928 Examiner N/A AGNES HOSPLTAN 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**X** M 2□ F 80 Maryland Director 218-22-1667 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho) traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 3300 Benson Avenue, Apt. 118 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 46—48 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Specify: ò White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipper Chemical I 2 should be filed w h and Mental Hygiel 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Conwell Thelma Ε. Gaimes Thomas Kinsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun 3300 Benson Avenue, Apt. 118, Halethorpe, MD 21227 Helen M. Kinsey - wife Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 5/22/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAYS a ATHERO SCIEROTIC CARDED VASCULAR DESEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown OBSTRUCTUR ARRWAY DEFERE 1 ☐ Yes 2 ☐ No CHRONIEC Completed 24b. Were autopsy findings available prior to completion of cause of death? SLEEP 24a. Was an CARDLOMYOPATHY APNEA. cate has page 2 s autopsy performed certificate 2 1 No 1 ☐ Yes 2 ☐ No 1 □ Yes ospital or Attending Physician: Thours after death.
uneral Director: After this certificat if filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 HNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

Registrar

29b. Signature and title of certifier

Dr. SRLDIHAR

31. Date filed (Month, Day, Year) MAY 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

BADEREDOI

MILLIAND

St AGNES HOSPITAL

29c. License number 121227

BALTEMORE.

29d. Date signed (Month, Day, Year)

2008

MAY

		4	For State Registrar	State of Mary		rtment of H		F	Reg. No.	8	166	92
ľ	Physici /Medic	al	Decedent's Name (First, Middle, Last)     Frederick	Alan	Koomand			2. Date of Dea Month May 13	Day	Year	3. Time of D	
	Examin Funeral Director	er	4a. Facility Name (If not institution, give s  Brooke Grove Reha  5. Social Security Number  089-20-6300	b & Nursin	ng Center n yrs. last birthday) Yrs.	4b. City, Town, or Sandy  If Under 1 Year  Months Days	Spring		Mont	gome	ry ace (State or York	Foreign
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. le marked other then "naturelt, or Items 23a or 28a-f show eumetic event, it a Medical Examinar must be notified at	eted by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number  10700 Montrose A	Venue  12. Was Decedent Eve Armed Forces?  1	945	Park  10f. Zip Code 20896  Nas Decedent of Hi Yes, specify Cuba  Yes 2X No  Ilent's Usual Occupations of work done of	ispanic Origin? (S in, Mexican, Puert Specify: ation during most of wor	pecify Yes or No o Rican, etc.)	10g. Citizen of W	/hat Count - America c, White, e	d. Inside City 1 □ Yes 2 ry? In Indian, tc. White	/ Limits
land 2121	be filed tal Hygi d other event, I	To Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Alexander Theode	College (1-4or 5+) 5+	Engîr	DO NOT use retired	18. Mother's Nar		Departn Maiden Sumami Cendry		of Ene	ergy
Baltimore, Maryland 2121	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 le marke eny injury or other treumetic ance.		19a. Informant's Name/Relationship (Ty, Heather Renehan) 20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun are Service License	Daughter	11600 20b. Place of Dispo cemetery, cren Money & Crematic	natory or other plac	Run La	ne, Glei Date 15/2008	n Allen, 20c. Location - Chantil 171 W	Va. City or Tov	23059 wn, State	e.
760,09	be executed which and hydrographic burial-transit b	icai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einst Unionlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the e cause on each line.  Lung Car  Due to (or as a co	o death. Do not enterpression of the consequence of						Approximate Interval Betwo Onset and De	reen
P.O. Box 68	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	]Fetal death 3 □	Ectopic pregnancy	,		23d. Date Mor	e of delive	-	ear
ords, P.	w requires that been signed by should be deta	Ď	Part II. Other significant conditions cor End Stage Chron	itributing to death but n	ot resulting in the untion Pulm	nderlying cause give nonary Di	en in Part I. Sease		obacco use contr Yes 2 □ No		e cause of de ably 4 ∐Ur	
al Reco		e Completed	25. Was case referred to medical					1 Yes	osy primed? d	Vere aulor rior to con leath?	psy lindings a poletion of cal 2 No	vailable use ol
Division of Vital Records,	tending Physicath.	Certification; To Be	examiner?  1 Yes 2 No  27. Manper of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yo		28c, Injur Worl M 1	er: 4 🔀 Nursing H	28d. Describe I	dence 6 Other	ed		D87,
<u>S</u>	To the Hospital or At- within 24 hours after d To the Funeral Direct completely filled in by	edical Certif	(Check only 2 Medical Exami	building, etc. (sician: To the best of mer: On the basis of ex	Specify) ny knowledge, death	n occurred at the lin		City or To	wn, State) cause(s) and ma	nner as st	ated.	
		Medi	one) 29b. Signature and title of certifier	23 Hame	Si M	29c. Licens	e number		29d. Date signed	i (Month, l		
	Sta Registi		Ata Motamedi, 31. Date filed (Month, Day, Year) MAY 2 2 2008	32. Registrar's	1811 Prin		o Dr.,O	lney, Mo	d. 20832			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Minnie Jane Kitchen 05-21-2:00 am<sup>M</sup> /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 👽 F 240-42-4734 Director 78 09-03-1929 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 940 E. Biddle St. 20212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No þ Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th h and Mental Hygie <u>School Bus Driver</u> Gladden Transport permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ephraim Holmes Willie Huey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Bowers-Husband 940 E. Biddle St. Baltimore, MD 20212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05-28-2008 Owings Nill, MD 4 Donation 5 Other (Specify) Garrison Forest Cem 22. Name and Address of Facility A R Mortuary & Funeral Svc 21. Signature of Funeral Ser 1722 N. Capitol St. NW Washington DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Human Virus months Immunoded disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans the death certificate be execu Due to (or as a consequence of) physician s the burial Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year 4 Pregnant at time of death 1 ☐ Yes 2 🗀 0 signed by the at be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHUSICIAN D53590 22,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 624 609 31. Date filed (Month, Day, Year) 3 Registrar's Signature State MAY 2 2 2008 Registrar

DHMH 17 Rev 1/2001

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 **Physician** 52 ttie man /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** County General Hos Columbia | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Worth Day. 7. Age (In yrs. last birthday) 7 Yrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 416-34-6897
Usual Residence of Decedent 1 □ M 2 🛛 F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Proportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once. 1 MYes 2 No **Funeral Director** 0. umbia towar 10e. Street and Numbe 10g. Citizen of What Country? 2101 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surna Be 19b. Mailing Address (Street and Number or Ryral Royne Number, City or Town, State, Zip Code)
5356 Old Stone Ct., Wilumbia, MD 3 21046 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 23.08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eumonia **Physician** & acule disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transi Due to (or as a consequence of) attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 K No Month 4 ☐ Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▶ 6 24a. Was an autopsy performed? Yes 2 No 1 □ Yes filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760, within 2 the

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State Registrar

y, Year) 22 31. Date filed (Month, Day, 2008

29b. Signature and title of certifie

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D50870

cane Clarksville MD 21029

State of Maryland / Department of Health and Mental Hygiene

/Medi	an	1 - For State Registrar Amend 4c, p  1. Decedent's Name (First, Middle, L  Rache1					2. Date of D Month	Day	Year	3. Time of Death
Exami		4a. Facility Name (If not institution, g	Ann Kais	5S	4b. City, Town, or	Location of Death		7,200	Oounty of Dea	11:35 A
Examin	er	11256 Falls Road	•		Timon				-	Baltimore
Funeral			Sex 7. Age (/	n yrs. last birthday	y) if Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bir	rthplace (State or Fore
Director		217-26-5005 Usual Residence of Decedent	<sup>1□M 2</sup> ▼F 78	Yrs.	Months Days	Hours Min.	June	16 19	29 М	D Country)
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Department of Important: If I any Injury or one	li	21. Signature of Furnit Service Lic			22. Name and Addre	ss of Facility				
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DHMH 17 Rev 1/2001

DHMH 16 Rev 6/95

State Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per / 12 880 6-13-08 yt and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of D 3. Time of Death **Physician** /Medical Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner 4b. City. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 K Months Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I's Medical Examina, must be notified at Director 1 ☐ **(**es 2 ☐ No timore 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working To DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) icelop and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ဂ 19a. Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 20c. Location Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22/08 Baltimore, MI 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death uch as cardiac or respiratory arrest, Do not enter the mode of dvin Immediate Cause (Final ancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be execulted and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 4 ☐ Pregnant 9 ☐ Unknown P.O. 1 the detached 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Name and address of person v empleted cause of death (Item 23a) (Type, Print) "lowscuteur Registrar's Signature 31. Date filed (Month, Day, Year) State 22 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #5, perFH C880 6/3/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 545 AM Ethel J. Light 2008 5 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 21,1923 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Country 1 ☐ M 2 🔀 F 215-7416

Usual Residence of Decedent Director Maryland the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes XXNo Directo Maryland Parkville Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 4102 Taylor Ave. 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Martinez Ella Johns 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 Rockbourne Road Mr. Jack L. Light, Jr. (Son) Dundalk, MD 34 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
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Important; If ite
any injury or ot
once. 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 5/19/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician BLeed ParieTo - occipital 5-12-8-5-15-8 resulting in death) /Medical Tie to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES0000 5-15-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selena Thomas 9000 FRANKLIN Square DR Balto md 21237 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

2 2 2008

200 SIM

			1 - For State Registrar	State of	Maryland		artment rtificate				fental Hyg	giene Neg. No.	800	16	699
	Physic	ian	Decedent's Name (First, Middle, )	Last)							2. Date of Dea Month	ith Day	Year	_	e of Death
	/Medi	cal	Kenneth Long  4a. Facility Name (If not institution, g	rive street and sumb	osl		4h Cib. T		1	( D 15	may	_	2008		30 AM
	Exami	ner	Prince George's				4b. City, T	<sub>own, or</sub> ever		or Death			ounty of Death		1 0
	Funeral			Sex 7.	Age (In yrs. las		If Under 1	Year	If Under	24 Hrs.	8. Date of Birth		O Dist	place (Stat	te or Foreign
	Director		252-98-3158	1 M 2 □ F	51	Yrs.	Months	Days	Hours	Min.	Nov 25,	1956	Cou	intry)	unk
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation							10d. Inside	City Limits
	Mary I eh	to	MD Prince	George's	Ch	ever1	У								es 27 No
	or 28s	lrec	10e. Street and Number				10f. Zip 0	Code			1	10g. Citize	n of What Cou	ntry?	
	ath wi	ral	2900 Mercy Lane					207	785				USA		
36	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f ehow ha Madical Examinar mast be notified at	by Funeral Director	11. Marital Status Un	Armed Force 1 Tes 2 If Yes, Give	\$? <b></b>		Was Decede f Yes, specif 1 ☐ Yes 2]		panic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, pecify: bla	etc.	,
8	tural stural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Date		16a Dece	dent's Usual	Occupa	tion		1		of Business/Ir		
21215	s within 72 liene. r than "ne the Medic	Completed	(Specify only highest of Elementary/Secondary (0-12) unk	College (1-40		(Give	kind of work DO NOT use	done du	uring most	t of worki	ng unk	166. Kind	or Business/ir	idustry	un
Maryland 21215-0036	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, La				unl	k	18. Mothe	r's Name	e (First, Middle, I	Maiden Su	umame)		unk
lary	and N is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (	Street au	nd Numbe	r or Rura	al Route Number	r, City or T	own, State, Zij	o Code)	
Baltimore, N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show way figury or other traumatic event, the Madical Examinat must be nutified at ance.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Prince George's Hospital Center 3001 Hospital Drive Cheverly, MD 20785  10a. Method of Disposition 1   Burial 2   Cremation 3   Removal from State 4   Donation 5 000ther (Specify) in state												
Baltir	permit. P Depertme Importan any injury once.		21. Signature of Fund Honor Specific Life Kona Life School			St	Name and	Address natc	of Facility	oard	655 W.	Ba1t	imore S	Stree	t
			23a. Parti. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the death.	Do not ent	or the mode	re, of dying,	such as o	2120 cardiac o	r respiratory arr	est,		Approxim Interval E	
	Physician		Immediate Cause (Final disease or condition	- Amy o		c La	Herra	10	-10	vio	Sic			Onset an	
н	/Medical Examiner		resulting in death)	Due to (or	as a consequen	ice of):					~			7	-0.3
	74	er	Sequentially list conditions, if any, leading to immediate	b. Due to for a	as a consequen	ce on:									
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			0.7.									
o,	cate be executed physicien and the burial-transit		resulting in death) Last	C. Due to (or a	as a consequen	ce of):									
8/60	ate be hysici the bu	dical		d											1 26 L
ē ×	eath certific ettending p	/Med	IF FEMALE:	00- 16											
O. Box	at the death certificate be executed by the ettending physicien and tached for use es the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown   12   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   1   1   1   1   1   1   1   1   1							230	23d. Date of delivery Month Day Year				
S,	signe d be d	þ	Part II Other significant conditions	contributing to death	but not resultin	g in the un	derlying cau	se given	in Part I.		23e. Did tob		contribute to the		f death?
ပ္	aw 2 sh	Completed	Ventrator	Acpen	den						24a. Was a	n 2	4b. Were auto	psy finding	s available
r	The ate h	E O	multiple		-, trus	ulco	15				autops perform 1 Yes 2	ned2	prior to co death? 1  Yes		cause of
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?					-		of Death	Check only one			E LINO	
6	Physic this c	2	1 Yes 2 No 27. Manner of Death		tient 2 ER/			Other	4 🗆 1401		ne 5 🗆 Reside			y)	
0	iding Ph th. After th funeral	tol	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of In (Month, D	Day Year)	b. Time of Injury	м 28с	. Injury a Work?	ıt əs 2∐N		8d. Describe ho	w injury o	ccurred		
DIVISION	of the death of th	ertification:	3 Suicide 6 Could not l	28e. Place of I	njury - At home etc. (Specify)	, farm, stre					8f. Location (Str City or Town	eet and N , State)	lumber or Rura	il Route Nu	ımber,
		edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner	of examination	ige, death and/or inv	onsumed at lestigation, in	the time my opir	, date and nion, death	place, a n occurre	nd dual to the ca d at the time, da	iusa(s) and ate and pla	d manual as sl ace, and due to	aled. the cause	n(s)
	within To th	Me	29b. Signature and title of certifier	17 ,		0		icense r					igned (Month,		
			Vanlles	Melo	el Gu			01	85	52	- /	nac	1112	000	5
			Name and address of person who	completed cause of	death (Item 23:	a) (Type, F	rint)	501	Red	H	1atts	ille	MID ?	2071	1
	Stat Registra		31. Date filed (Month, Day, Year) MAY 2 2 200	AND THE RESERVE OF THE PERSON NAMED IN COLUMN TO SERVE OF	trar's Signature		E)								

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		State of Maryland / Department / Departm		•	ne								
Physiciai /Medica Examine	n il	1. Decedent's Name (First, Middle, Last)  Francis Albert Lee  4a. Facility Name (If not institution, give street and number)  Union Memorial Hospital  4b. Ci	ty, Town, or Location of Death Baltimore	MAY 1	Day Year 3. Time of Death 10: 2644. County of Death								
Funeral Director		216-12-2517 <sup>1</sup> ∇M 2□F 84 Yrs. Month	der 1 Year   If Under 24 Hrs. Is Days   Hours   Min.	8. Date of Birth (Month, Day, Yea Jan 2, 19	9. Birthplace (State or Foreign Country) 24 Maryland								
be filed within 72 hours after death vial Hygiene. d other than "natural", or items 23a event, the Medical Examiner must	lo be completed by Fur	2704 E. Joppa Road  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 8  17. Father's Name (First, Middle, Last) Frank Lee  19a. Informant's Name/Relationship (Type. Print)  Diana J. Carter/niece  20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State	nt seaman  18. Mother's Name  Doris A  ess (Street and Number or Run  Joppa Road Ba	ecify Yes or No-Rican, etc.)  16b.  16c (First, Middle, Maid.  20c Ann Smail  21d Houte Number, Cit.  21d Limore,	City or Town, State, Zip Code)								
Physician /Medical Examiner	ical Examiner												
attending for use a	Priysiciari/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown	23c Did tobaco	23d. Date of delivery Month Day Year									
n: The law requires that the de ficate has been signed by the r, page 2 should be detached	confibrered by	Part II. Other significant conditions contributing to death but not resulting in the underlying	1   Yes  24a. Was an autopsy performed 1   Yes 2 2 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	24b. Were autopsy findings available prior to completion of cause of									
To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	2	25. Was case referred to medical examiner?  1	28d. Describe how in	and Number or Rural Route Number,									
To the Hospital within 24 hours: To the Funeral completely filled	enical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurr on the basis of examination and/or investigat and manner stated.  29b. Signature and title of certifier  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  21 Date filed (Month Day, Year)	and place, and due to the cause(s)										
State Registra	,	231. Date filed (Month, Day, Year)  MAY 2 2 2008  MAY 2 3 2008  MAY 2 3 2008	RIAL HOSP. B	SDES (MC	ord,								

Registrar DHMH 17 Rev 1/2001

State

Genevieve Wroblewski,

MAY 22

2008

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

3. Registrar's Signature

M.D. 1355 Piccard Drive Rockville, MD 20850

08-03737 UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

3737 ( UNK		Please Type or Print in Black Indelible State of Maryland / Department	of Health and Mental	Hygiene	2008 1670
		For State Certificate	of Death	Reg. No	3. Time of Death
Physician dical Examine	<i>I</i> 1.	ngistrar Decedent's Name (First, Middle,Last)  Michael ALVIN  M	ORRIS	2. Date of Death Month Day May 16, 2008	Year 0930 hrs
MCai Examini	4:	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Do Baltimore	eath	4c. County of Death
		4223 Colborne Road  Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or
Funeral Director	- 1	. Goodal Geografy Herman		Min. Jan. 23	1962 Foreign Country) Md,
		Isual Besidence of Decedent			10d. Inside City Limits
w any	1	0a. State 10b. County 10c. City, Town or Lo	timore		1 Yes 2 No
land f sho	힐닏	[7]	10f. Zip Code	10g. (	Citizen of What Country?
AD 21215-0036  2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show manic event, the Medical Examiner must be notified at once.	Director	S27 Wildwood Parkway	21229		14. Race - American Indian, Black,
vith th			Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Po	? ( Specify Yes or No- uerto Rican, etc.)	White, etc.
eath v	Funeral	1 Never Married 2 Married Armed Forces?	,		Small BlACK
ter de		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:	16	b. Kind of Business/Industry
hours afte "natural", Examiner	핡	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Education (Specify only highest grade completed)	edent's Usual Occupation (Give kin ng most of working life. DO NOT us		B. And of Business/mousey
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours af ment of Health and Mental Hygiene. The filem 27 is marked other than "natural or other traumatic event, the Medical Examin or other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	WELDER	1	Steel Findust
vithin ene.	티	10-7-1	18 Mother's	Name (First, Middle, Mai	den Surname)
5-0 Hygi		17. Father's Name (First, Middle, Last)	ma	riprie	morable
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hyggiene. Important: If item 27 is marked other than mijury or other traumatic event, the Medical	å	Raymond Morris  19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street and Numb	er of Rural Route Numbe	r, City or Town, State, Zip Code)
hould Man is m:	의	0.1	7 Wildwood F	Kuy. Ba	Lto indi 21229 Coc. Location - City or Town, State
MD 1d 2 shoulth and in 27 is aumati	-	20b. Place of D		Date 2	Oc. Location - City or Town, State
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Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Mount	MITCHELL CEM	5766	CHASE CITY, VIOLINIA
altic nit. ] sartm sorta	ŀ	21. Signature of Funeral Service Ligensee	22. Name and Address of Facility	270 mean	TILION FILM
ii ii De B	-	Stand 1. March	Jany Pimare	h f. H. Do	t. shock, or heart Approximate Interval
Physician		23b Farth Enter the disease, or complications that caused the death. Do not e folium. List only one cause on each line.	nter the mode of dying, such as ca	rolac of respirately all as	Between Onset and Death
		Immediate Cause (Final disease a. Multiple Gunshot Wounds			
aminer		or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b			
	ner	if any, leading to immediate  cause. Enter Underlying Cause			
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ecuted and transit	ŭ	events resulting in death) Last			
xecuted n and l - transi	cai	UNPENDED AMENDED			The Landson Control of the Control o
Ox 68760, eath certificate be ex attending physician for use as the burial	Physician/Medic	IF FFMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
68760, certificate be nding physicise as the buri	Σ	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic	pregnancy	Month Day Year
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O. B at the d 1 by the tached			in the underlying cause given in Fa		2 No 3 Probably 4 Unknown
ires that the signed by it be detached	d b				an 24h. Were autopsy findings available
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SOF law r has b	횰			perfor	O No
Rec The l icate l	Completed		26.Place of Death	(Check only one)	
Division of Vital Records, tat or Attending Physician: The law requinrs after death.  The That the tart this certificate has been so an Director: After this certificate bas been selled in by the funeral director, page 2 should the	B B	25. Was case referred to medical	tpatient 3 DOA Other		Residence 6 🗸 Other: Scene
Vit hysic this	2	1 Yes 2 No	ime of Injury 28c. Injury at Wor		now injury occurred
n of \ ding Phy After the				<ul> <li>ISubject sho</li> </ul>	
on lendi sath.	읥	1 Natural 5 Pending May 16, 2008 0917 2 Accident Investigation Accident Accident Pending May 16, 2008 0917	hrs		Street and Number or Rural Route Number, City
IVISIOR or Attendather death Director:	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, fail	m, street, factory, office building, e	an Tourn C	State) e Road, Baltimore, MD
itato ra af led i	t	4 V Homicide determined (Specify) Alley			
Hosp 4 hou Fune elv fi			th occurred at the time, date and p	lace, and due to the caus	and place, and due to the cause(s)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician from the earth literator. After this certificate has been signed by the attending physician from the earth of the corresponding to the former of the physician from the property page 2 should be detached for use as the burial	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death o	necarred at the time, see	29d. Date signed (Month, Day, Year)
To wit	N N	29b. Signature and title of certifier	29c. License numbe	er ·	1
		1 (ando Hall) ain	O.C.M.E.		May 17, 2008
L.		30. Name and address of person who completed cause of death (Item 23a)			
1		Carol Allan, MD Assistant Medical Examiner 111	Penn Street, Baltimore, M	D 21201	
2		Louis de Sienaturo	1 1.		
Ren	Stat	MAY Z Z ZUUO Kanena Kr	Gorde		

DHMH 17 Rev 1/2001 OCME 2006

08-03687 Brian Michael Meye Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Michael Me			State	e of Maryland		ment of I ficate of I		Menta		Na	20	108	67
		- For State Registrar			Certii	icate of t	Dealii	_	2, Date of Dea	eg. No. th		3. Time of Death	
Physicia	-	1. Decedent's Nam	ne (First, Middle,La	ist)	ED<				Month May 14, 2	Day Yea 008	ır .	1254 hrs	
শন্al Examir	ier -	15/21AN	O MICE	IAEL MY	r)	41	o. City, Town, or L	ocation of		4c. County of	of Death		
		University h		170 00 001 001	,		Baltimore		22				
Funeral		5. Social Security	•	Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year	If Under		th (MM/DD/YYYY	9. Birth Foreign	place (State or	
Funeral Director				M 2 F	49	Yrs.	Months Days	Hours	Min. 03/0	3/1959	Cour	ntry) MARY	CUAL
		220-72- Usual Residence	00 11	▼ IVI 2			<u>.                                    </u>	<u></u>				10 1 1 11 01	Limite
any		10a. State	10b. County		10c. City, To	own or Locatio	on				L	10d. Inside City	
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rylan a-f st	용	10e. Street and N	umber	01-062	0,5		10f. Zip Code			10g. Citizen of W		try?	
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ith th		11. Marital Status		12. Was Decede	nt Ever in U.S.	13 1/25	Decedent of His	panic Origi	in? ( Specify Yes or N Puerto Rican, etc.)		e - Americ te, etc.	can Indian, Black	ί,
ath w items	uneral	1 Never Mar		ied Armed Force	2 No		/		Fuerto Ricari, etc.)				ł
her de	ш	3 Widowed	han and and	ced If Yes, Give Year			Yes 2 No			Specify: 16b. Kind of B		11TE	
ours a	d by	15. Decedent's l	Education (Specify	y only highest grade c		16a. Decedent	t's Usual Occupations of working life.	ion (Give k . DO NOT (	use retired)	Tob. Kind of B	USI11622/11	ilidusti y	
72 ho	Completed	_	condary (0-12)	College (1-4 o	or 5+)			MOS	DIVER	1005	TRU	CTION	
036 Aithin ene.	를	19			(	(ON).11	CIOTON	18 Mother's	s Name (First, Middle				
<b>21215-0036</b> July be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she is event, the Medical Examiner must be notified at once it event, the Medical		17. Father's Nam	e (First, Middle, L	S MYERS	70				250RIE 1				
121 d be f fental narke	Be	100 Informant's	Name/Relationship	n (Type, Print )	, 512.	19b. Mailing	Address (Stree	et and Num	ber or Rural Route N	umber, City or To	wn, State	, Zip Code)	
D 2 shoul and N 7 is m	오			H / AUNT	-	438	ROSE	Yah	BEL AIR	W7 5	1016	4	
and 2 sh cealth and tem 27 is		20a. Method of D	Disposition		20b. Pi		ition (Name of ce	metery,	Date	20c. Location			1
Baltimore, MD 21215-0036  semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Melkeal Examiner must be notified at once.	1			3 Removal from	State	SENT (	OFMATO	RY	W6,66 YAM	K HANG	SLAVE	CM	
Baltimore permit Pages I Department of I Important: If injury or other		4 Donation	5 Other Spe Funeral Service L	cify:	HIL	1 22. N	Name and Address	s of Facility	Y				
Balt permit Depart Impor injury						1	577 100	コンノニ しし	EA DILLA	STEN H	うのより	NR.MDS	31076
Physician		23a. Part I. Enter	r the disease, or c	omplications that caus	sed the death.	Do not enter t	he mode of dying	, such as c	cardiac or respiratory	arrest, shock, or h	reart	Between On	set and
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c 68 certi endin	Physician/M	past 12 mor		7	nt at time of de		Other (Specify)						
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ires the signed the d	2								24a. W	as an 24	b. Were a	autopsy findings	available
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eco ne lav te has	Completed									es 2 No	1 🗸	Yes 2	No
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of ving Phy		27. Manner of I		28a. Date of (Month) Apr 29, 2	of Injury Day Year)	28b. Time o 1710 hrs	f Injury 28c. In	njury at Wo	_ iSubject :	assaulted	Carrot		
on ath.		1 Natural	o i circ	anig						on (Street and N	umber or	Rural Route Nur	nber, City
Division of Vital Records, tal or Attending Physician: The law requirer after death.  To albrector: After this certificate has been so led in her the fineral director name 2 should the fineral director name 2 should the fineral director name.	6	3 Suicide	6 Coul	ld not be 28e. Place			reet, factory, office	e building,		vn, State) les Drive and N			
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif	Continued in my uncontinued	4 V Homici	ide		Local Stre			d-4- 00d (					
e Hos 124 h e Fun			Certifying P	hysician: To the best	t of my knowled of examination a	dge, death occ and/or investig	curred at the time, gation, in my opini	ion, death	occurred at the time,	date and place, a	ind due to	the cause(s)	
To th Withir	complete	١,	and title of certific	and mainer st	ated.			ense numb	er	29d. Date	signed (f	Month, Day, Year	-)
	1	296, Signature	and title of Certific	. 0/-		•	0.0	C.M.E.	OCME	May 15	, 2008		
		The	ohn 10	4 knog	My m	m 23a\							
3			address of persor re M. King, Jr.	who completed daus MD. Assista	se of death (itel int Medical	Examiner	111 Penn	Street, E	Baltimore, MD 2	1201			
	Q		(Month, Day, Year)		egistrar's Signa								
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DHMH 17 Rev		- 565	11 10 10	Janes		ORIGIN	NAL						

			110000	State of Ma	ryland				d Mental Hy		-cgibic.		
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	Q		Decedent's Name (First, Middle, La	st)					2. Date of De Month		Year	3. Time of	Death
	Physici /Medic		William	michae	21				MAY	18	2008	5:10	AM
	Examin		4a. Facility Name (If not institution, gire	4 4	.1 .		4b. City, Town, or			4c. (	County of Dea		
ŀ		,	BIVERVIEW Re  5. Social Security Number  6. Security Number		<u> </u>	h Cente	If Under 1 Year	5 e X			777-1	thplace (State of	
	Funeral Director			MTM 201E	89	Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da July 2)	y Year)	C	ryland	ir Foreign
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	arylar show	ř	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside C	-
	the M 28a-f	Director	Maryland Baltin 10e. Street and Number	ore	Esse	X	10f. Zip Code			10a Citiz	en of What C	<u> </u>	
	Mith Ba or			a			21221					ouritry :	
	death ms 23	Funeral	965 Woodlynn Roa	12. Was Decedent E	ver in U.S	i. 13. y		spanic Origin	? (Specify Yes or No Puerto Rican, etc.)	U. S	4. Race - Ami		
٥	after or ite		1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give	0		r Yes, specify Cuba I□Yes 2□XNo	n, mexican, P Specify:	uerto Hican, etc.)		Black, Whi Specify:	te, etc.	
2-003e	172 hours after death with the Maryland "naturel", or Items 23a or 28a-f show idical Evaminat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	WW II						W	hite	
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and	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Las	)					Name (First, Middle,				
<u>a</u>	D 2 0 0	ToE	John Michael	,				Ruth	Fuss				
Mar	d 2 shou th and M 7 is mar treumati		19a. Informant's Name/Relationship			19b. Mailir	g Address (Street a		or Rural Route Numbe				
	s 1 and of Health item 27 other to		Katherine Michae  20a. Method of Disposition	l (Wife)	20h Pla		Woodlynn		Essex, Man		nd 2122 Pation - City or		
و	0 5 = 5		1 XBurial 2 Cremation 3				sition (Name of natory or other plac	<sup>e)</sup>	721 2008				,
saitimore,	permit. Pag Department Importent: Imy injury c		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	• •	Oak		Cemetery Name and Address				imore,	Maryla	nd
ğ	Depi Impo		Michael C	Jallian.	550	B. 1	ruzdzinsk 407 Old F	i Fune astern	eral Home I Avenue I	PA Essex	. Marv	land 21	221
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	iplications that caused	the death.						-, ::::: ]	Approximat Interval Bet	е
	Physician		Immediate Cause (Final disease or condition	Pa	vk.	Eco	$\mathcal{A}$	seal	e.			Onset and	
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):							
	Lxammer	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	S to	ste	Canc	01					
V	nsit	nine	Cause (Disease or injury	Due to (or as a	,	1					1		
1	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	conseque								
,00	ite be execu iysician and ne burial-tra	cal	(	o Chra	٧٠٢	0	Luch	e ou	brownery's	dill	2000		
20	tifica ig ph as th	Medi	IF FEMALE:					V	/				
nox	that the death cer ed by the attendin detached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2	2 Fetal o	death 3	Ectopic pregnancy			2	3d. Date of de Month	,	Year .
		yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of dea	ath 5□	Other (specify)					,	
7	that the ed by detact	/ Ph	Part II. Other significant conditions	contributing to death bu	t not resul	ting in the ur	nderlying cause give	on in Part I.	23e. Did t	obacco us	e contribute t	o the cause of c	leath?
cords	law requires that the as been signed by th 2 should be detache	d by	Maenic						1	res 2	]No 3 <b>(</b> ¥P	robably 4 🔲	Jnknown
S S	s bee	olete							24a. Was		24b. Were a	utopsy findings	available
He	0 5 0	Completed	-						autor perfo	rmed?	death?	completion of c	ause of
VITA	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						Death (Check only	ne)			
0	S II	ို	1 ☐ Yes 2 🗙 No			R/Outpatien	t 3 DOA Cthe	Pr: 4 Nursi	ng Home 5 ☐ Resid			ecify)	
	ding Phy h. After thi funeral c	ertification:	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Injury Work	·?	28d. Describe I	now injury	occurred		
VISION	er death rector: by the I	licat	2 Accident investigation 3 Suicide 6 Could not be	e con Diago et laive	rv - At hon	ne farm str		Yes 2□No		Street ario	Number or R	ural Route Num	her.
2		ertii	4 Homicide determined	building, etc.	(Specify)	, 10, 11, 31,	sot, ractory, office		City or To		770,770		501,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	alC	29a. Certifier 1 Certifying P	nysician: To the best of	f my know	ledge, death	occurred at the tim	e, date and p	place, and due to the	cause(s)	and manner a	s stated.	
	he Ho in 24 he Fu	edical	one)	miner: On the basis of and manner stat	led.								
	With To I	Σ	29b. Signature and little of cartifier	M.O			29c. License	number	٠. ا	29d. Date	signed (Mon	th, Day, Year)	
	1		4				1000	7)31.	71		17/17	108	
	1521		30. Name and address of person who	completed cause of de	ath (Item :	23a) (Type,	Print)	سر ما هم	Rost	20-	MO	21221	_
	Sta	te	31. Date filed (Month, Day, Year)	2000 32. Registra	r's Signati	irght /	hade	CARG	FIBUHA	~~ C	1 2		
5-2	Registr		MAY 2 2	2008 32. Registral	Alex a	Mr. Jak							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per dvr 9879 5-22-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 19 2. Date of Death 3. Time of Death eedent's Name (First, Middle, Last) **Physician** imond NTH 2008 12:20AM /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F Country) 2 218-60-5662 Yrs. 2-10-1954 Director RAYMONDO 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at 1XYes 2 ☐ No Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Aue Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 vivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "yay injury or other traumetic event, the Masones. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THEW Matthews ames elen ansome 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Box 6 MD 3/33 20c. Location - City or Town, State 1monao Thems 20b. Place of Disposition (Na 20a. Method of Disposition Burial 2 ☐ Cremation 5/23/08 Crownsville, \* 4 ☐ Donation 5 ☐ Other (Specify) possof Figure Francial Services Francial Services (Services Francial Services Francia Services Francia 21. Signature of Funeral Service Licenses Services 2 IDA Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of do or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit NEUTROPENIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria LYMPHOMA CELL Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MASS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown ANEMIA LUNG Completed BRAIN LYMPHOMA THRU MBULY TOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DIABETES MELLITUS SPLENECTOMY 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred o the Hospital or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number sha MD RESOUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud, Baltimore, MD 21239 10 Roshan

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State Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month McDOWELL DENNIS 6:45 PM MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HAVEN NURSING HOME CATONSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) Mar 18, 1939 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2□ F 220-36-7214 69 Tennéssee Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 'natural", or Items 23a or 28a-f shov dical Examiner must be notified at Director MD 1 ☐ Yes 2 No Baltimore Catonsville within 72 hours after death with the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Edmondson Avenue 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: black þ 3 Widowed 4 Divorced Year or Dates: Completed item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. But: If item 27 is marked other than machine operator Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Edward MCDowell Pearl Locke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith McDowell/niece 2411 N. Stockton Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stelle 4□Donation 5 NOther (Specify) in state 21. Signalum of Funeral Syrvic State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Obse (Final Athero schoolis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last gicinama Due to (or as a consequence of Examiner requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☑Unknown Completed mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s nas certificate 1∐ Yes 2 1 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Yes 2N No 1 Inpatient P 2 ☐ ER/Outpatient 3∐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: the Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after e Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica

Registrar

31. Date filed (Month, Day, Year) 2008 MAY 22

29b. Signature and title of certifier

Honoton Macen

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN N NAME 501 D 32 Registrar's Signature

olphin st. Baltimore MD 2/217

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)
May 16 2008

within 24

### 08-03320

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

onn	ie Edward l	1	For State	Certificate of		Reg. No.	200	18 1570			
	Physicia		egistrar . Decedent's Name (First, Middle,Last)			Date of Death     Month Day		3. Time of Death 0141 hrs			
F	ા Exami	ner	Donnie Edward Matthews	<del></del>	b. City, Town, or Location of D	May 1, 2008	c. County of Death				
			a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	"	Baltimore						
	Funeral			(In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Birth (MM	I/DD/YYYY) 9. Birth Cou	nplace (State or Foreign unky)			
	Director			50 Yrs.		Dec 1, 1	957				
	ıny	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location								
	Maryland 28a-f show any d at once.	2	MD	Balti			1 X Yes 2 10g, Citizen of What Country?				
6.	17215-0036 Id be filed within 72 hours after death with the Maryland Id befiled within 72 hours after death with the Maryland sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 4201 Primrose Avenue		10f. Zip Code 21215	10g. Ci	USA	iu y r			
3	ith the 23a or		11 Marital Status UNK 12. Was Decedent E	ver in U.S. 13. Wa	s Decedent of Hispanic Origin	? ( Specify Yes or No-	14. Race - American Indian, Black,				
7	leath w r items	Funeral	1 Never Married 2 Married Armed Forces?	No unk	es, specify Cuban, Mexican, P	Puerto Rican, etc.)	White, etc.	lack			
	safter c ral", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade compared to the compare		Yes 2 X No specify: nt's Usual Occupation (Give kir	nd of work doneink 16b					
	2 hours "natu		Elementary/Secondary (0-12) College (1-4 or 5-	during m	ost of working life. DO NOT us	se retired)					
	036 rithin 7 ene. er than	Completed	unk unk		unk 18.Mother's	Name (First, Middle, Maide	en Surname)	unk			
	21215-0036 uld be filed within 72 Mental Hygiene. marked other than "		17. Father's Name (First, Middle, Last)		UIIK 16.Moulers	Manie (1 1131, Middle, Maise	,,, Comente,				
	212 ould be Menta mark	To Be	19a. Informant's Name/Relationship (Type, Print )		g Address (Street and Numb			e, Zip Code)			
	more, MD 21 Pages 1 and 2 should nent of Health and Me ant: If item 27 is ma or other traumatic ev	Ċ	O.C.M.E.		Penn Street I		c. Location - City or	Town, State			
	Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta		ther place)						
	Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 X Other Specify: in state	22.1	Name and Address of Facility	1 (55 77 7	0 - 1 + 4	Ctmoot			
	Balt permit. Depart Impor		21. Sig ature o Funeral Se Licensee NO ITALL S. Wady Dire	r ika	name and Address of Facility ate Anatomy Bo 1timore, MD 2	21201 W. I	saltimore	Approximate Interval			
	Physician Wedical	1	23a. Pal I. Enter the diseas, or c. n. dications that caused failul. List only one suse on each line.				shock, or near	Between Onset and Death			
1	_xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a conse		erotic cardiovascu	ılar disease					
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	ed sit	Ξxaπ	events resulting in death) Last	equence of):							
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	certificate be executed nding physician and sea as the burial - transise as the burial - transit - tr	Physician/Medical	IF FEMALE: 23c. If yes, outcor	me of pregnancy		1	23d. Date of delive Month	ery Day Year			
	687 certific nding 1	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 4 Pregnant at		etal death 3Ectopic  Other (Specify)	pregnancy	Month	20,			
	Box 68760, e death certificate be the attending physic ed for use as the bur	hysic	1 Yes 2 No 9 Unknown 9 Unknown		de de la companio Pa	et l 23e Did tobac	cco use contribute f	to the cause of death?			
	Division of Vital Records, P.O. Box 6876 pilal or Attending Physician: The law requires that the death certificat ours after death. After this certificate has been signed by the attending the filled in the fineral filterin mace 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to deat Seizure disorder; schizophre		e underlying cause given in ra			obably 4 🗸 Unknown			
	Division of Vital Records, P.O. Into Attending Physician: The law requires that its after death.  The law requires that it after this certificate has been signed by and in by the fineral director mase 2 should be detacted.	eted	Delicare absorder, business			24a. Was an autopsy	24b. Were a	autopsy findings available o completion of cause of			
	e law re has b	Completed				performe	ed? death?				
	I Re In: Th rrificat	ြင်	25. Was case referred to medical		26.Place of Death						
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	n of ding P h. After	::   0	27. Manner of Death 1 X Natural 5 Pending	Year)	1 Yes 2	,					
	ision Attend er death. irector:	Certification:	2 Accident Investigation 28e. Place of to	njury - At home, farm, st	reet, factory, office building, et	tc. 28f. Location (Street or Town, State	eet and Number or	Rural Route Number, City			
	Div Hospital or 24 hours aft Funeral Di	l in	determined (Specify)  Homicide								
283. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Montal Examination)											
									1		
			30. Name and address of person who completed cause of Ana Rubio MD. Assistant Medical Exal		Street, Baltimore, MD	21201					
		State	24 Peter Clad (Advarts Day Vond) 32 Registr	rar's Signatur	aske)						
		State	MAY 2 2 2008	w w M							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No., Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical ocation of Death (If not institution, give street and number) Examiner Date of Birth (Month, Day, Year) (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 45 213-88-0855 MD Director Aug. 8, 1962 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 23a or 28a-f show must be notified at 1 √Yes 2 No Director Baltimore MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 21223 49 S. Carrollton Avenue Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give tems 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2☐ Married **Black** 'natural', or 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Yes, Give ear or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aramark prep cook Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Joyce Harrison Edward H. Madison, Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 S. Carrollton Avenue; Baltimore, Maryland 21223 Cassandra Madison / Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 05/22/2008 Randallstown, Maryland King Memorial Park 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 21217 638 N. Gilmor Street; Baltimore, Maryland 23a. Part1. Enter the disease, or comp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician POCOCCO disease or condition resulting in death) /Medical r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine I or Attending Physician: The law requires that the death certificate be executed after death. use as the burial-tran physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ Oo 24a. Was an autopsy After this certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 □ Alatural 2 □ Accident 28a. Date of Injury 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature

DHMH 17 Rev 1/2001

2

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

			Pleas	e Type or Prir						•		•	е.			
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Examir				give street and number)			4b. City, To	wn, or L	ocation of Dea			County of E	Death			
<b>*</b>	7		JOHNS HOPKINS HOSPITAL Baltimos													
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Director		Usual Residence of			- 07					09/	29/1	920	ebai	.1011		
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shou and M s mar	-	19a. Informant's N	19a. Informant's Name/Relationship (Type. Print)				ling Address (S	Street ar	nd Number or F	Rural Route Numb	er, City o	or Town, Sta	ite, Zip i	Code)		
and 2		Gabriel	Najjar/	Son						Silver S	prin	g, MD	209	905-		
Sest of He or other other of the other oth		20a. Method of Dis	•	3 □Removal from State	20b. P	lace of Disp emetery, cre	position (Name ematory or other	of er place	5/1	Date .0/2008	20c. Le	ocation - City	y or Tov	vn, State		
Pag tment tant:		4 □ Donation	5 ☐ Other (Sp	ecify)		_			tory In		Ве	ltsvil	le,	Maryland		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of	Funeral Service U	icensee	N 003	82   2	22. Name and A			emation S	ervi	ces				
ENGLE		23a, Part1, Enter	the disease, or o	complications that caused	the deat	n. Do not er				<b>lver Spri</b> ac or respiratory a		Maryla		Approximate		
Dhysisian		shock, or he Immediate Cause	eart failure. List o	inly one cause on each li	ne.	/	2+	2	,					Interval Between Onset and Death		
Physician /Medical		disease or conditi resulting in death)	ion	a. Due to (exas	a consequ	uence of):	enegl	2					+			
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n certi	n/M	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome								23d. Date o	f delive	у		
death e atte	icia	in the past 1: 1 ☐ Yes 2	2 months?	1□Live birth 4□Pregnant a			☐Ectopic preg ☐ Other (spec				Month Day Year			Day Year		
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w requires that the d	by	Part II. Other sign	nificant condition	ns contributing to death b	ut not res	ulting in the	underlying cau	ise giver	n in Part I.		tobacco Yes 2	/		e cause of death? ably 4 □Unknown		
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has the general person of the second person of the	Completed									24a. Was		24b, Wei	r to con	sy findings available apletion of cause of		
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ysicia s cert	o B	examiner?		Hospital: 1 Inpatie	ent 2	ER/Outpatie	ent 3 DOA	Othor		Home 5□Res		6 □Other (	(Specify	7)		
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or Att fter de Direct in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	al a é a usa i u		ury - At ho c. <i>(Specif</i>	ome, farm, s y)	treet, factory, o	office		28f. Location City or To			or Rural	Route Number,		
To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier	CertifyInc	Physician: To the best	of my kno	wledge dea	ath occurred at	t the time	e date and nia	ce and due to the	cause/s	and mann	er as st	ated		
e Hos 24 hc e Fun etely	Medical	(Check only one)	2□ MeBical E	xaminer: On the basis of and manner st	f examina	tion and/or	investigation, in	n my op	inion, death oc	curred at the time	, date an	d place, and	d due to	the cause(s)		
To the within To the Complex	Me	29b, Signature an	title of certifier		and manner stated.  29c. License number 29d. Date sig						ate signed (A	Month, L	Day, Year)			
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			dress of person v	who completed cause of c	eath (Iten	1 23a) (Type	e, Print)					, ,				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician OWRUTSKY SELMA 19,2008 7:30P MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GENESIS BRIGHTWOOD NURSING HOME BROOKELANDVILLE Months Days Hours Min. Date of Birth (Month, Day, Year) 1/17/1927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 81 MD 216-20-8125 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exercitive must be notified at 1 □Yes 2√ No Director MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 11202 VALLEY HEIGHTS DRIVE items 23a 21117 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 □Yes 2X No Specify. WHITE 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURERS REPRESENTATIVE FURNITURE permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any lijury or other traumatic event, I've and Jourse. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BENJAMIN SHANNON ESTHER OSHRY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 276 CEDARMERE CIRCLE OWINGS MILLS, MD 21117 NEIL OWRUTSKY / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 5/21/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic non-small cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division of Vital Records, To the Hospital or Attending hours after death. within 24

> State Registrar

29b. Signature and title of certifier

Laura M

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Muniford MO

10755 Falls Rd

32. Registrar's Signature

29c. License number

D0018410

Lutherville

29d. Date signed (Month, Day, Year)

108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:15p M **Physician** Mary Claire Palardy 2008 20 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore 3427 E. Pratt Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/24/1926 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min Months 1 □ M 2 🔀 F 81 219-22-8872 Baltimore, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified at 1√2 Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21224 3427 E. Pratt Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Our Lady of Fatima Substitute Teacher 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline Denz Carl J. Thomas ပ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traumonce. 6801 Gough St., Baltimore, MD 21224 Claire Polsinelli 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 5/23/08 Most Holy Redeemer 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr.FH 21. Signature of Funeral Service Licenses 263 S. Conkling St.Baltimore, MD 21224 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, liv one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Firm 140 CARDIAL INFARCTION Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1ABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Replacement Valve physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHOLESTEROL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy 2 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760%attending p sbeen signed by the should be detached cate has t page 2 s certificate the Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

72 hours after

Baltimore, Maryland 21215-0036

5

Medical

31. Date filed (Month, Day, State Registrar

29a. Certifier

(Check only onel

29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

808 S. CONKLING ST. BALTIMORG, MD 21224 5. SIMPLER

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Year) 22 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 10b, perFH,8879 5/22/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 0505 02 hel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** R. Burton Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 3 - 9 -6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2**X**F 1.88-38-06X Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 Yes 2 No Funeral Director MD timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or must be r Gorman USA Nor Pages 1 and 2 should be filed within 72 hours after death vant of Health and Mental Hyglene.
ant: If Item 27 Is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ndary (0-12) College (1-4or 5+) 17. Father's Name (First. Middle, Last Mother's Mame (First, Middle Be ٥ V05 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ave., Balto, and 21223 Daughter Nov 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signal re of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** End Renal Disease /Medical Due to (or as a consequence of) **Examiner** Preumonia Sequentially list conditions, any learning transport in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examiner The law requires that the death certificate be executed P.O. Box 68760, E Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Clostridium Diffici 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CVA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy perform certificate Dementia To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) 2 No 1 Yes Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Specify) hours after death.

Ineral Director: After this y filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 60 628 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Estheroh Ben Lulew 5505 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Verna M. Powers Mayonth 7, 2008 **Physician** 6:25 A M /Medical 4a. Facility Name (If not institution, give street and number)
Brighton Gardens 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 28,1906 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 📆 Months 213-42-4859 101 Iowa Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner cust be notified at 1 □Yes 2 □ No MD Director Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code ō death with 6451 N. Charles Street 21204 U.S.A. 23a Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXXIII If Yes, Give Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 3√No Specify Specify: White 3 3 dowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 +18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last)
Edward Ellsworth Marken Bessie Louise Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) If item 27 is James M. Powers (Son) 8415 Kellogg Court Lutherville, MD 21093 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 5/20/08 Catonsville, MD 5 ☐ Other (Specify) 4 Donation Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Balto, MD 21211

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, simple of the disease of the cause of the death and the death and the death are death are death and the death are 21. Signature of Funeral Service 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final RRIATRIC FRATLT **Physician** 4COVS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Physician/Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician the attending p for use as use as IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo 4 Pregnant at time of death Month Day Year 5 Other (specify) the detached 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findiogs available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dether (Specify) to Si Jozef Wit 1 Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death For dide 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Registrar

29b. Signature and title of certifier

31. Date filed (Month)

w

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATWIN J. CHARLES WY CTO! N. CHARLES ST TOWN NO 21204

58303

29d. Date signed (Month, Day, Year)

MAY 20 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc 9879 5–28–08 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Betty Louise Redelius Month **Physician** 21, 2008 May 5:08 P M Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Anne Arundel 525 Nolwood Court Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 8. Date of Birth Sept. 19 7. Age (In vrs. last birthdav) **Funeral** Days Hours Months 1 □ M 2 🖾 F 80 215-22-0011 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f shi t be notified a 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 525 Nolwood Court 21061 U.S.A. 23a must Funeral 14. Race - American Indian Black, White, etc. items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗓 No Specify: White à 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event, the once. Receptionist Law Firm d 2 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Walter O'Brien Mary Elizabeth Sturgeon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Raymond W. Redelius/Husband 525 Nolwood Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, MD Cedar Hill Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wh /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed erreni and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the Se nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ong) Hospital: Other: 4 Nursing Home 3 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending (Month, Day Year) N. Himural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C the Hospital completely filled ₩ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

ATIR

au)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 MRIUA

32. Registrar's Signature

29c. License number

0-0052205

3501 S. HANDUER STREET,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedents Name (First, Middle, Las Month Year **Physician** MAY 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SAMARITAN HUSPITAL Year If Under 24 Hrs. 8. Date of Birth Month, Day, Y Birthplace (State or Foreign Country) If Under 1 al Security Number 7. Age (In yrs, last birthday) Days Hours -40-2962 0 Director Usual Residence of Decedent death with the Maryland 10d, Inside City Limits 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 **S**res 2 □ No Baltimore MD **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 1 Mever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) Argel a Sewell (Cou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltmore, InD 21207 Lousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 5.27.08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Probable Immediate Cause (Final disease or condition resulting in death) Myscerdial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of) Examiner requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): Box 68760, physician sthe burial Physician/Medical attending p for use as 33 IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) o been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an cate has page 2 s autopsy performe certificate Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10058570 5601 LOCH RAVEN BLUD BALTIMIRE, M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TERRANCE L. BAKEL, M. D. 3 ERRANCE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

32 Registrar's Signature

			State of Maryland		cate of D		_	Reg. No.	008	16717
			Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Joseph Leonard Reeley				May	13	2008	4:30PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b.	. City, Town, or I	Location of Death		4c. Cour	nty of Death	
			Union Memorial Hospital			Baltimo:				
П	Funeral	9	5. Social Security Number 6. Sex 7. Age (In yrs. It	Mo	Under 1 Year onths Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th i <i>y, Y</i> ea <i>r)</i>	9. Birthpi	lace (State or Foreign try)
le,	Director		212-36-4812 / //	Yrs.			12/	09/1937	Mar	ryland
	and w		Usual Residence of Decedent  10a, State 10b, County 10c, City	, Town or Location	n				10	0d. Inside City Limits
	faryl sho ed at	ō								1 <b>%</b> Yes 2 ☐ No
	the N	Director	MD Baltimore City Ba	altimore	Of, Zip Code			10g. Citizen o	of What Coun	itry?
	with a or	ā						3		•
	eath ns 23 musi	era	2700 St. Paul St.  11. Marital Status  12. Was Decedent Ever in U.3	S. 13. Was	21218 Decedent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	)- 14. R	ace - Americ	an indian,
	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No				Rićan, etc.)	В	lack, White,	etc.
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7		Completed	9							
2	al Hygie I other	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surn	ame)	
<u></u>	should be filed and Mental Hygi s marked other umatic event, t	2	William D. Reeley Sr.			Dolores	Purdy			
Maryland	an an		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Ad	ddress (Street a	nd Number or Ru	ral Route Numb	er, City or Tov	vn, State, Zip	Code)
_	1 and 2 Health em 27		William Reeley/Brother		ring Ct	. Apt.			·	MD 21219
altimore,	iges 1 nt of Hi if iter	-	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	lace of Disposition emetery, cremator	n (Name of ry or other place	9)	Date May 1		n - City or To	own, State
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<u>a</u>	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Na	me and Addres	•	3140		_	
n	9 9 5 6 9		July Some Retter	87	17 Green		Drive	Baltim		ryland 21286
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		e mode of dying	g, such as cardiad	or respiratory a	arrest,		Approximate Interval Between
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	Physician		immediate Cause (Final disease or condition Severe. CV	monic C	)hstruc	tive Pu	lmonar		ase	Onset and Death
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8/60, 6/	/Medical Examiner		If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):	Obstruc nt In	tive Pu rection	lmonar ns		ase	Onset and Death
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_	/Medical Examiner	edical	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 13 months?  23c. If yes, outcome pf pregnant 1 □Live birth 2 □ Fetal	uence of):  uence of):  uncy I death 3 □Ectr	opic pregnancy	tive Pu Hection	lmonar ns	y Dise	Date of deliver	2yrs
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend 4b &4c, perMD, g879 5/22/08 TT Certificate of Death 2. Date of/Death Physician /Medical Examiner Baltimore Catonsville If Under 1 Year If Unde yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 □ F Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Examiner must be notified at 10d. Inside City Limits 10a. State Town or Location 1. Tes 2 No by Funeral Director 10f Zin Code 10g. Citizen of What Country 10e Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary Secondary (0-12) lege (1 Surname) ٩ Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit completely illied in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 dnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: Other: 4 Nursing Home 1 Yes 2 N Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 L 31. Date filed (Month, Day, Registrar's Sign Year) State MAY 22 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per ft 9879 5-22-08 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 720P **Physician** 2008 18 /Medical 4b. City, Town, or Location of Death 4c. County of Death itution, give street and numbe Facility Name (If not inst Examiner meltimore Ci Has MMORE Date of Mrth (Month, Pay, If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 6. Sex **Funeral** ay, Year) **-194**0 1 □ M 2 □ 478 Veu2 Director 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tes 2 No more Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: filed within 72 hours after of Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joshua Bailey Be 2 19b. Mailing Address (Street and Department of Health an Important: If item 27 is any injury or other trau 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 HRS MN 10 cond **Physician** /Medical Due to (or a a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Dissass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 3 Ectopic pregnancy Year detached for u Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 NO 1∐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient

Division or Vital Records, P.O. Box 68760,

this certificate has ral director, page 2 To the Hospital or Attending Physician: funeral director, After

Medical Certification: To Be Completed by

within 24 hours after death

To the Funeral Director:

0

State Registrar 2 Accident 3 ☐ Suicide 4 Homicide

29b. Signature and title of certifier

27. Moner of Death

1 Natural

(Check only one)

6 ☐ Could not be

5 Pending investigation

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year) 18

lann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IARIA WHAR 31. Date filed (Month, Day, Year) MAY 2 2 2008

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** <u>2008</u> /Medical 4b. City, Town, or Location of Death (If not institution, give street and number) Examiner rowsor Date of Birth (Month, Day, If Under 1 Year | If Under Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. Baltimore 1 No 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 awnvie Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodbridge, VA 2219
ate 20c. Location - City or Town, State Flanagan OU Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Femation 3 ☐ Removal from State 123/2008 Baltimore, MI) 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 1 C. Greene Funeral Services Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. 4905 York Approximate Interval Between Onset and Death Immediate Cause (Final (mmmo DeA EIENCY Physician disease or condition resulting in death) ue to (or as a consequence of) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 XNc the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Injury 1 Natural 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20 2000 30. Name and address of person who completed cause of death (Item 23a) (Type 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0216 THAN 1 DUGE SHE TTERLY 20 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Howard Columbia If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year
Months Days **Funeral** Hours Min. Mary Land 1 ☐ M 2 🕱 F 212-30-0597 Director 74 01/07/1934 Usual Residence of Decedent 1 2 should be filed within 72 hours after death with the Maryland name and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State пs 23a or 28a-f show 1 ☐ Yes 2 🙀 No MD **Funeral Director** Howard Elkridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6391 Rowanberry Drive Apt. 311 United States 21075 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Examiner 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: White Baltimore, Maryland 21215-0036 Specify Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard O. Coram Edna Louise Tyson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau William E. Shetterly, Jr./ son | 6112 Hunt Club Road Elkridge, MD 21075 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Meadowridge Memorial Park 1 Burial 2 □ Cremation 3 □ Removal from State 05/22/2008 | Elkridge, Maryland 4 Donation 5 Dother (Specify) 21. Signatura of Fune & Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring RD Arbutus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiomyorathy Immediate Cause (Final disease or condition resulting in death) Ischemic Physician /Medical Due to (or as a consequence of): Examiner Atheroscleratic Cardiovaccular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed Diabetes mellatus physician and is the burial-tran Due to (or as a consequence of): Box 68760, as 1 IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 No 3 Probably 4 Unknown Completed Gastrointestinal 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Chronic Obstructive certificate 2 1NO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 After this within 24 hours after death.

To the Funeral Director Are completed. 28d. Describe how injury occurred funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0043662 20,2008 mn MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

Registrar
DHMH 17 Rev 1/2001

State

William

31. Date filed (Month, Day, Year)

Howard
32. Registrar's Signature

08-03387 John Paul Snyder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

min r aut Stryder	1- For State  Certificate of Death  Reg. No. 2006	1672
Physician	Registral 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Tin	ne of Death 30 hrs
ledical Examin	John Paul Snyder May 3, 2008	- ISO HIS
	4a. Facility Name (if not institution, give street and number)  7801 Eastern Avenue  4b. City, Town, or Location of Death  Dundalk  4c. County of Death  Baltimore County	
Funeral Director	5. Social Security Number $un$ 6. Sex $1 \times 10^{-1}$ 7. Age (In yrs. last birthday) 6. Sex $1 \times 10^{-1}$ 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace of Birth(MM/DD/YYYY) 19. Birthplace of Birth(MM/DD/YYYYY) 19. Birthplace of Birth(MM/DD/YYYYY) 19. Birthplace of Birth(MM/DD/YYYYY) 19. Birthplace of Birth(MM/DD/YYYYY) 19. Birthplace of Birth(MM/DD/YYYYYY) 19. Birthplace	e (State or unk
апу	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d.	Inside City Limits
ě .,	MD Baltimore Dundalk	Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 8440 Kavanaugh Road 10f. Zip Code 21222 USA	
death with	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American In White, etc.	
hours after "natural", o	3 Widowed 4 Divorced In Yes, Give Year 1 Yes 2 A No specify: Specify: Specify: WITTLE	
nan ' 72	15. Decedent's Education (Specify only highest grade completed)    Elementary/Secondary (0-12)   College (1-4 or 5+)   unk   17. Father's Name (First, Middle, Last)   16a. Decedent's Usual Occupation (Give kind of work done Unk during most of working life. DO NOT use retired)   16b. Kind of Business/Industred during most of working life. DO NOT use retired)   16b. Kind of Business/Industred during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Surname)   16b. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16b. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired)   16c. Kind of Business/Industred during most of working life. DO NOT use retired   16c. Kind of Business/Industred during most of working life. DO NOT use retired   16c. Kind of Business/Industred during most of working life. DO NOT use retired   16c. Kind of Business/Industred during most of working life. DO NOT use retired   16c. Kind of Business/Industred during most of working life. DO NOT use retired   16c. Kind of Busin	, dik
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than e event, the Medica	φ	unk
MD 21 d 2 should the and Mer in 27 is mar	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.C.M.E.  111 Penn Street Baltimore, MD 21201	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medical	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 X Other Specify: ix state  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town.	, State
Baltin permit. J Departm Importa injury o	21. Signature of Euneral at ryice Licensee State Anatomy Board 655 W. Baltimore S  Renald St. Wase Director  Paltimore MD 21201	treet
Physician	23a Part I. Enter the disease or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Api	proximate Interval etween Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):	Death
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	<del></del>
	Cause: Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying (Disease or injury that initiated events resulting in death) Last Underlying (Disease or injury that initiated events resulting in death) Last Underlying (Disease or injury that initiated events r	
ecuted and transit	g.	
60, ate be executed obysician and re burial - transi	UNPENDED AMENDED 23d Date of delivery	
Box 68760, to death certificate be executed the attending physician and ed for use as the burial - transit	F FEMALE:   23d. Date of delivery   23d. Date of del	Year
D. B. It the de		ause of death?
res that the signed by	1 Yes 2 No 3 Probably  24a. Was an autopsy prior to compl death?  1 Yes 2 No 1 Yes autopsy prior to compl death?  1 Yes 2 No 1 Yes 2 No 1 Yes	
ords w requi	24a. Was an 24b. Were autopsy prior to compl	y findings available letion of cause of
Recol The law cate has	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital Recystician: The libit certificate director, page	25. Was case referred to medical control of the con	
of Vital Recing Physician: The After this certificate uneral director, page	Properties 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outrer 4 Nursing Home 5 Residence 6 Other: Scenario Company 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
on C ending ath. or: Aff	1 Vatural 5 Pending (Month, Day, Year)	
Division of Vital Records, ital or Attending Physician: The law require urs after death.  ral Director: After this certificate has been sittled in by the funeral director, page 2 should be assured.	1 V Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  1 Yes 2 No  1 Yes 2 No  28f. Location (Street and Number or Rural R or Town, State)	toute Number, City
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 2  29c. License number  29d. Date signed (Month, L	use(s)
# \$ F 8		Day, Year)
	Worming Ine Grill O.C.M.E. May 4, 2008	
	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	te 31. Date filed (Month, Day, Year) 32 (Registrar's Signature	
Registi	MAY 2 2 2008 Steene D. Comme	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Ö 2001 1:570M Deams Smith 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BeHimore M 21239 Bo Someon teh HOSKI to 600d If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F unk 84 Director 232-30-1900 Oct 16, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notifled at Director MD 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 E. Melrose Avenue 21212 USA Funeral unk 12. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk Health and Mental Hygivem 27 is marked other Maryland 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk Pages 1 and 2 should be nent of Health and Mental or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any Injury or other trau Good Samaritian Hospital 5601 Loch Raven Blvd Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Euneral Source S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 bais **Physician** /Medical Due to (or as a consequence of); 'En'lletion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trail Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 denknown been : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | No 1 4Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 4 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

d

30. Name

29b. Signature and title of certifier

Lock

erson who completed cause of death (Item 23a) (Type, Print) Rebell Blo Belt weere

32. Registrar's Signature

Blol

29d. Date signed, (Month, Day, Year)

Good Some or to

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ame (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Howard Columbia **Howard County General Hospital** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Director MD 83 218-18-6170 Jan 18, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at Director 1 Yes 2 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6722 Allview Dr. 21046 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 ģ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. **Quality Engineer** Military If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Shipley Margaret Gilbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Scott Shipley 4930 Arthur Shipley Rd. Sykesville, MD 21784 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 23, 2008 Elkridge, Maryland Meadowridge Memorial Park, 21. Signature of Furieral Syrvice Licel 22. Name and Address of Facility 23a. Part 1. Enter the disease, or com shock, or heart failure) List only Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 or or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed P.O. Box 68760, burial-tran and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 this certificate has been sign al director, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□Yes 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA hours after death.

neral Director: After this y filled in by the funeral d 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Stat

State Registrar

MAY 2 2 2008

Year

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

			For		State of Ma	aryland /				Mental Hy	giene		
			State Registrar				Cer	tificate of L	Death	,	Reg. No.	008	15725
	Physici /Medic		1. Decedent's Nam	e (First, Middle, La:	A		SA	RIEGO		2. Date of De	1 8 P	7008	3. Time of Death-
	Examir		to a second		e street and number)	HASP	TAI	4b. City, Town, or	MBA-	1		nty of Death	
-35-	Funeral		HOWARD  5. Social Security N	COUNTY Jumber 6. S	ex, 7. Ag	e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		190-18-7	<b>135</b>	M 2□F	83	Yrs.	Months Days	Hours Min.	(Month, Da <b>May</b>	14, 1925	Con	intry) W. VA
	pu ,		Usual Residence of			10c. City, T	own or Loo	ation					10d. Inside City Limits
	laryla shov	ក	10a. State	10b. County	ward	Toc. City, 1	OWIT OF LOC	attori	Ellicott City	v			1 Tyes 2 No
	the N 28a-f	Director	10e. Street and Nu		Ward			10f. Zip Code			10g. Citizen	of What Cou	untry?
	3a or		3229 Birch	mede Dr.				·	21042			U.S.	.A.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 ☑ Widowed	ried 2☐ Married	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:			/as Decedent of Hi Yes, specify Cuba ☐ Yes 22 No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	E	Race - Amer Black, White ecify: Wh	, etc.
5-0	72 ho natui lical	eted	(Spec	15. Decedent's Ed	ducation ade completed)	1	6a. Deced	ent's Usual Occup kind of work done of ONOT use retired	ation during most of wor	king	16b. Kind o	f Business/II	ndustry
7	within iene. <b>than</b> "	Completed	Elementary/Seco		College (1-4or 5	i+)	`life. D		<sub>ຶ່</sub> ງ chinist	J		Lat	oor
7	filed w Hygie ther t			(First, Middle, Last	)			ITIO	18. Mother's Nan	ne (First. Middle	. Maiden Suri		
anc	Suld be f Mental I arked of atic eve	To Be	7. I dillor 3 Hamo	(r not, matrio, Laot	Henry Sari	ego					Elvira Ald		
Maryland	A B E E	F	19a. Informant's N	ame/Relationship (			19b. Mailing	g Address (Street	and Number or Ru	ıral Route Numb	per, City or To	wn, State, Z	ip Code)
	nd 2 alth a 27 ls		Ms. Marily	n Saboe da	aughter		3229	Birchmede	Dr. Ellicott	City, MD 2	1042		
ore	a 0		20a. Method of Dis		Removal from State	20b. Plac	e of Dispos etery, crem	sition (Name of natory or othe <mark>r pl</mark> ac		Date		on - City or T	
<u>Ë</u>	Pages tment of I tant: If its jury or o		4 ☐Donation	5 ☐ Other (Special	ý)			inic Cemeter		21, 2008		Philade	lphia, PA
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fi	uderal Service Live	L Moo	2535	22.	Name and Address Slack Fu 3871 Old	ss of Facility Ineral Home, I Columbia Pi	P.A. ike Ellicott (	City, MD 2	1043	
			23a. Part1. Enter	the disease, or com art failure. List only	plications that caused one cause on each li	I the death. I	Do not ente	er the mode of dyin	ng, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	CON	GEST	IVE	HEAR	T FAI	WRE		(	Onset and Death
1	/Medical Examiner		resulting in death)		Due to (or as	a consequen	ce of):	15014	EMIA				
E	<b>1</b>	<u>_</u>	Sequentially list co	onditions,	b. Due to (or as	a consequen	ce of):	Tari	EMIR				
1	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or that initiated event	erlying r Injury	,		,						
,	execting and rial-tra	Exa	resulting in death)	Last	Due to (or as	a consequen	ce of):						
68760,	icate be executed physician and s the burial-transit	ical			d.								
	ertifica ing ph e as th	Physician/Medical	IF FEMALE:										
Box	eath certifi attending for use as	ian/	23b. Was deceder		23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pregnancy	/		23d.	Date of deli Month	very Day Year
	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ Unknowr	□No	4□Pregnant at 9□Unknown	t time of deat	h 5[_	Other (specify)					
, P.O	de de		Part II. Other signi	ificant conditions	contributing to death b	ut not resultir	ng in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?
rds	quires n sign ald be	d by	_ HYPE	RTENSIO	N					1 🗆	Yes 2□N	o 3 Pro	obably 4 Donknown
Records,	law requir as been si 2 should t	Completed								24a. Was	an 2	4b. Were au	topsy findings available completion of cause of
Ä	The laste has page	E O								perf 1⊟ Yes	ormed?	death? 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case refe examiner?	rred to medical					26. Place of Dea	ath (Check only	one)		
or V	Physic this ce al dire	P	1 ☐ Yes 2 ₺	No		ent 2 ER			4 LI Nursing F	lome 5 Res			cify)
Ň	ding P	ii ii	27. Manner of Bea 1 Natural	5 Pending	28a. Date of Inju (Month, Da		Bb. Time of Injury	28c. Injur Wor M 1 □		28d. Describe	how injury oc	curred	
Division	I or Attend after death. Director: /	icat	2 ☐ Accident 3 ☐ Suicide	investigatio	e   280 Plano of ini	urv - At home	e. farm. stre	eet, factory, office	Yes 2 No	28f. Location	(Street and N	umber or Ru	ıral Route Number,
Ρį	after Direction by	Certification:	4 🗌 Homicide	determined	building, et	c. (Specify)	, ,	,,,		City or To	wn, State)		,
	Hospita 4 hours Funeral ely filled	Medical C	29a. Certifier (Check only one)		nysician: To the best miner: On the basis o and manner st	f examination							
	To the I within 2. To the I complet	Me	29b. Signature and	d talle of certifier			A (	29c. Licens					h, Day, Year)
	- > - 0		▶ (W	MAN	PHY C	SICI	AN	Da	05212	-2	MA	118	12008
	5		30. Name and add	ress of person who	completed cause of d	leath (Item 23	3a) (Type, 1						21044
	Sta	ate	31. Date filed (Mo)	nth, Day, Year)					·				
	Regist	rar	MAY	1 2 2 2008	1 Paller	B. A	MARKE						

ician	1 - State Registrar		Ot	ertificate of	Dealli		Reg. No.	1000	101
CIGIL	1. Decedent's Name (First, Middle	, Last)				2. Date o Month		/ Year	3. Time of Deatl
dical	Jeanne W.	Townshend				MAY	21	2008	6:45 p
niner	4a. Facility Name (If not institution	, give street and number)		4b. City, Town, o		eath	4c.	County of Death	
	Renaissance Gar			Catons  If Under 1 Year		Ira Tana		Baltimor	
al or	5. Social Security Number  212-26-9462  Usual Residence of Decedent	6. Sex 7. Age (IIII) 7. Age (IIII) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	n yrs. last birthdag	Months Days		in. 8. Date of (Month	f Birth , <i>Day</i> , <i>Year)</i> <b>26 192</b>	4 New	place (State or Fore htry) <b>Jersey</b>
	10a. State 10b. County	10	0c. City, Town or I	_ocation				1	0d. Inside City Lim
ţō	MD Balt	imore	Catons	ville					1 □ Yes 2 <b>X</b>
irec	10e. Street and Number		Outons	10f. Zip Code			10g. Citi	zen of What Cour	ntry?
Funeral Director	709 Maiden Cho	ice Lane		21228			ŀ	USA	
ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedent of H	lispanic Origin?	(Specify Yes o		14. Race - Americ Black, White,	
E.	1 Never Married 2 Marri			1 ☐ Yes 2 XNo		ierto mean, etc	''	Coocifu	
d by	3 Widowed 4 Divorced	Year or Dates:						WIL	
Completed	15. Decedent (Specify only highest	's Education t grade completed)	16a. Dec (Giv	edent's Usual Occup re kind of work done DO NOT use retire	oation during most of v	working		nd of Business/Incial Secu	-
lg I	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler		a)			inistrat	•
	17. Father's Name (First, Middle,	l ast)	OTEL	icai	18 Mother's N	Name (First, Mi			7011
Be	Ira Foster							_	
2	19a. Informant's Name/Relationsh	Wildey	10h Mai	ling Address (Street	Miria		Wri		Codal
	Gail H. Townshe	nd - daughter	1202	Inglesid		e, Gwyn	n Oak,	MD 212	07
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Si	3 ☐ Removal from State		nt Cemeter  Cemeter		Date <b>24/200</b> 8		eltenham	•
	21. Signature of Funeral Service Stev	en H. William	s	22. Name and Addre MacNabb	ess of Facility Funera	1 Home.	P. A.		
ш	8-H	aller		301 Fre	derick l	Road, C	atonsv	ille, MD	
		complications that caused the only one cause on each line.	100	,		diac or respirate	ry arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	_a.	F my	Myrem	a				Onset and Deat
	resulting in death)	Due to (or as a co	onsequence of:	/					
<u>.</u>	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a co	onecamono of:						
ij.	rany, leading to immediate	Due to (or as a cr							
	Cause (Disease or injury							-	
xam	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co							
al Examiner	that initiated events	c							
	that initiated events	c							
Medical	that initiated events	d	onsequence of):			-		23d. Date of delive	ery
Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	onsequence of):  pregnancy Fetal death 3	□Ectopic pregnanc	у			23d. Date of delive	ary Day Year
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08-03721

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Nathaniel Turk 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death nt's Name (First, Middle, Last) Physician/ Month Day May 15, 2008 2144 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Howard County General Hospital Columbia 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** oreign Months Days Hours Director 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Severn 28a-f show must be notified at once. Directo 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Vas 1 Yes 2 No specify: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", of injury or other traumatic event, the Medical Examiner is Specify: Widowed Divorced If Yes. Give Year \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 VIOTORS MD 21215-0036 ath 18.Mother's Name (First, Middle, Maiden Surname . Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print.) evern dil 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place) Burial Cremation 3 Donation 5 Other Specify: 21. Signature of Funers Service Licenses 23a Part / Enter the disease, or complications that caused the death. Do not enter Approximate Interval **Physician** Between Onset and List only one cause on each line Medical Death a Streptococcus viridans endocarditis complicated by narcotic Imme tale Cause (Final disease xamine Due to (or as a consequence of): intoxication or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician for use as the burial -#M5A,27,28a-f, perME,g880 6/5/08 TI Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown g 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been s ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 2 No No the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes ۵ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 Yes 2 X No Natural Pending within 24 hours after death. 5/15/2008 To the Funeral Director: completely filled in by the 9:20 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. unit 28f. Location (Street, and Number or Rural Route Number, City 3 6 X Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Dat egistrar's Signatu State 2008

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roger Turner 3:40P.M 2008 11. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Mar. 12, Bon Secours Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 247-40-3849 1 🔀 M 2 🗆 F Georgia 77 1931 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryia Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. Y□Yes 2 No Director Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21217 1033 N. Gilmor Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 6th grade Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Turner Hubert Starks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1011 Brantly Avenue Baltimore, Md 21217 Andrew Turner/ Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lansdowne, Maryland 5/16/08 Mt. Zion Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licen Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part I. Enter the dis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a de sequence of) law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

0

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

State Registrar 31. Date filed (Month, Day, 1)

29b. Signature

30. Name

au Registrar's Signal 29c. License numbe

29d. Date signed (Month, Day, Year)

08-03800 Maurice Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

,		tificate of Death	Reg. No.	08 16/2
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year  May 18, 2008	3. Time of Death 1832 hrs
1.	4a. Facility Name (if not institution, give street and number) 3100 Block East Biddle Street	4b. City, Town, or Location of Dea Baltimore	th 4c. County of De	eath J/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. la 216-76-0925 XXM, 2 F 49	**	Fo	Birthplace (State or reign Country) MD
and show any nce.	Usual Residence of Decedent  10a. State	Town or Location Baltimore		10d. Inside City Limits 1XXYes 2 No
	10e. Street and Number 1401 Kenhill Avenuė	10f. Zip Code 21 21 3	10g. Citizen of What C	Country?
E : E	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer	to Rican, etc.) White, etc	nerican Indian, Black, c. Black
2 hours "natur LExam	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th Grade  College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re  Mechanic	etired)	ess/Industry emotive
21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE COMPIE	17. Father's Name (First, Middle, Last) John Taylor		ne (First, Middle, Maiden Surname)  M. Allen	
MD 21 d 2 should d 2 should lth and Mer n 27 is man summatic ev	19a Informant's Name/Relationship (Type, Print ) Katie Taylor/ Mother	19b. Mailing Address (Street and Number of 1401 Kenhill Aven	ue Baltimore, M	ID 21213
Baltimore, permit. Pages 1 and Department of Heal Important. If teen injury or other tra	1 XXBurial 2 Cremation 3 Removal from State Kill	Place of Disposition (Name of cemetery, or other place) ng Memorial Park 5	Contract the second	stown, MD
Balt permit Depart Impor injury	21. Signeture of Funeral Service Licensee	22. Name and Address of Facility C	ad Baltimore, M	ID 21206
Physician /Medical rxaminer	23a. Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of	and narcotic intoxication	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	):		
uted Id ansit Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of d.	):		
760, icate be executed physician and the burial - transit	Xunpended AMEN, 27, 28a-f, pe	rME,9880 6/25/08 TT		
Box 6876 re death certificat the attending physel for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant in the Live birth  4 Pregnant at time of deal growth in the past 12 months?	2 Fetal death 3 Ectopic preg	nancy 23d. Date of deli	very Day Year
i, P.O. Be ires that the designed by the able detached it id by Physical By Ph	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute  1 Yes 2 No 3	e to the cause of death?  Probably 4  Unknown
cords law requ has been 2 should			autopsy prior deat 1 ✓ Yes 2 No 1 ✓	
n of Vital Recing Physician: The Independent of the Independent of	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2	26.Place of Death (Check ER/Outpatient 3 DDA Other: 4 Nurs	k only one) sing Home 5 Residence 6 🗹 0	ther: Scene
n of hading Ph. th.: After t e funeral	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work? Fnd 6:25 pm 1 Yes 2 No	28d. Describe how injury occurred UNK	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune-	2 Accident Investigation 5/3 5/10/2000	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number of or Town, State)	
To the Host within 24 hc To the Fun completely i	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination are	ge, death occurred at the time, date and place, a	nd due to the cause(s) and manner as	stated.
To vivit	29b. Signature and title of certifier  The land W. Thi The The	29c. License number O.C.M.E.	OCME 29d. Date signed May 19, 2008	
	30. Name and address of person who completed cause of death (flem Theodore M. King, Jr., MD. Assistant Medical E		ore, MD 21201	
State Registrar	31. Date filed (Month, Pay, Year) 2008 32 Registrar's Signatu	? Back		

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1.	Registrar  I. Decedent's Name (First, Middle, L.	ast)			ficate of		2. Date of		Law W/ W	3. Time of Deat		
cian ical		Baby Trejo						Month	L	2008			
iner	4:	la. Facility Name (If not institution, gi	ive street and number)			4b. City, Town, c	r Location of Death		4	c. County of De	ath		
		The Johns Hopkins I				Baltimore							
	5.	5. Social Security Numbeunk 6.	Sex <b>unk</b> 7. Age (1	In yrs. last bi		If Under 1 Year Months Days	Hours Min.	8. Date of (Month, May	Birth Day, Year 1, 20	008 Ma	irthplace (State or For ountry) ryland		
	_	Jsual Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	vn or Loca	tion					10d. Inside City Lin		
ţo		MD		Balti	more						1 Yes 2		
Director	1	Oe. Street and Number				10f. Zip-Code			10g. (	Citizen of What C	ountry?		
lal		2719 E. Fayette	Street				21224			USA			
Funeral	1	1. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of I res, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or Rican, etc.)	No-	14. Race - Am Black, Wh			
d by F		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:			∑Yes 2 No	Specify: mex	kican			white		
Completed		15. Decedent's (Specify only highest g		16	(Give ki	nt's Usual Occu nd of work done O NOT use retire	during most of work	king	16b	Kind of Busines	s/Industry		
E G	ı	Elementary/Secondary (0-12) infant	College (1-4 or 5+) infant	1		ant	u)		i	nfant			
ပိ		17. Father's Name (First, Middle, Las					18. Mother's Nan	ne (First, Mic					
To Be		Jose Jackson					I	Jidia '	Trejo				
-		19a. Informant's Name/Relationship			_	•	t and Number or Ru				Zip Code)		
		Johns Hopkins H	ospital	'	600 1	I. Wolfe	Street E	3s1tim	ore,	MD 212	87		
To Be Completed by Funeral Director	20	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ☒ Other (Spec				tion (Name of tory or other pla	ce)	Date	20c.	Location - City of	or Town, State		
	2	21. Signature of Euneral Service Lice Renal d S	Wade Dryec	tor	Sta	Name and Addr	ess of Facility Omy Board	1 655	W. Ba	ltimore	Street		
	5	a. Part I. Enter the dise se. or co	and time to caused the	e death. Do	not enter	timore,	MD 2120		rv arrest.		Approximate		
ð	1	shock or heart failure. If st only one cause on each line.  Interval Between Onset and Death											
	d	disease or condition resulting in death)	a. Extreme		rat	urity							
		•	Due to (or as a c	consequence	e ot):	J							
ē i	Sit	Sequentially list conditions, if any leading to immediate	b Due to (or as a c	consequence	e of):								
Examiner	C	Cause (Disease or injury											
		that initiated events resulting in death) Last	Due to (or as a c	consequence	e of):				-				
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sician/	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at tin 9  Unknown	☐ Fetal deat		Ectopic pregnan Other (specify) _	су			23d. Date of o Month	felivery Day Year		
by Phy		Part II. Other significant conditions	s contributing to death but	not resulting	g in the un	derlying cause	given in Part I.				to the cause of deat		
								1	☐ Yes	2 No 3	Probably 4 Unkr		
0	-							a	vas an utopsy erformed es 2	prior t death			
omplete		25. Was case referred to medical	1				26. Place of Dea			101	63 2 110		
e Completed		examiner?		2 18 50/0	Outpatient	3 □ DOA Ot	hor:	,		6 ☐ Other (Sp	necify)		
Be	. 2		Hospital: 1 ☐ Inpatient	ZJENEN/C						tono a constant			
To Be	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b	. Time of	28c. Inju		28d. Descr	ibe how ir	ijury occurred			
To Be	2	1 ☐ Yes 2 XNo	28a. Date of Injury (Month, Day Ye	28b	. Time of Injury	Wo		28d. Descr	ibe how ir	njury occurred			
To Be	2	1 ☐ Yes 2 No  27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b	Injury	M 1	rk?	28f. Locatio		and Number or	Rural Route Number,		
Certification: To Be	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine  29a. Certifler (check only 2 Medical Ex	28a. Date of Injury (Month, Day Ye  28e. Place of injury building, etc. (  Physician: To the best of n  aminer: On the basis of ex	28b (Specify)  my knowledgexamination a	Injury farm, stree	M 1 cet, factory, office	rk? ]Yes 2 □ No ime, date and place	28f. Location City or	on (Street Town, Sta	and Number or ate)	às stated.		
To Be	2	1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigate 3   Suicide 4   Homicide 6   Could not determine  29a. Certifier 1   Certifying I	28a. Date of Injury (Month, Day Ye 28e. Place of injury building, etc. (  Physician: To the best of reaminer: On the basis of evand manner state	28b (Specify)  my knowledgexamination a	Injury farm, stree	M 1 control of the state of the	rk? ]Yes 2 □ No ime, date and place	28f. Location City or	on (Street Town, Sta the cause time, date	and Number or ate)	às stated. due to the cause(s)		
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edical Certification: To Be	2	1  Yes 2 No  27. Manner of Death 1 Natural 5  Pending investigat 3  Suicide 6  Could not determine  29a. Certifier (check only one)	28a. Date of Injury (Month, Day Ye 28e. Place of injury building, etc. (  Physician: To the best of maminer: On the basis of evand manner state	- At home, 1 (Specify) my knowledg xamination a	Injury farm, stree ge, death and/or inve	M 1 ct, factory, office occurred at the estigation, in my	rk?  Yes 2 \( \text{No} \)  ime, date and place opinion, death occurse number .	28f. Location City or e., and due to curred at the t	on (Street Town, Sta the causime, date	and Number or ste) e(s) and manner and place, and of the place of the	às stated. due to the cause(s)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		rtment of ⊦ <i>tificate of l</i>			iene g.No. 🤈 💍	00 1070
	ysicia Medic		1. Decedent's Name (First, Middle, Last)	Tudinas	>			2. Date of Death Month	Day 10	Year 1115 M
	amine		4a. Facility Name (If not institution, give s Anne Arundel Medi	· ·		4b. City, Town, or Annapo	Location of Death $1  m is$		4c. County of	of Death rundel
Fun Dire	eral ctor		212-32-3909	7. Age ( <i>In yrs</i> . 60	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 22,	Year) 1947	9. Birthplace (State or Foreign Country) Maryland
Maryiand -f show	hed at	ī	Usual Residence of Decedent  10a. State 10b. County  MD Anne Aru:		ty, Town or Lo				_	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the or 28a	as rectif	Direc	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	/hat Country?
<b>Baltimore, Maryland 21215-0036</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	ACTION COURT	by Funeral Director	1242 Crowsnest Con  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Mid Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			21401 ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	A. e- American Indian, k, White, etc. e- white
21215-0036 d within 72 hours aft giene. er than "natural", or	e Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grade	year or Dates: cation e completed)  College (1-4or 5+)	(Give	_	during most of work f)	ing	16b. Kind of Bu	,
and 2 I be filed vental Hygie	event, It	Be Co	17. Father's Name (First, Middle, Last) William Edward Ty		LII	e changer	18. Mother's Name	e (First, Middle, N	automot faiden Surnam	
Maryland to 2 should be file th and Mental Hy tris marked oth	Iraumatio	2	19a. Informant's Name/Relationship (Type	pe. Print)	1		and Number or Rur	al Route Number,		. = -
Baltimore, N permit. Pages 1 and Department of Healtl Important: If item 27	ry or other t		Linda Castaneda/s  20a. Method of Disposition  1 Burial 2 Cremation 3 B  4 Donation 5 Mother (Specify)	20b. Femoval from State		Newm111 ( sition (Name of natory or other place	Ct Virgin:			City or Town, State
balti permit. Departm Importa	any Inju once.		21. Signatur of Fineral Services icenses	ade Director	Ва	1timore,	MD 2120	1		ore Street
Physic /Med Exam	ical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Milions that caused the deat the cause on each line.  Due to (or a./ a conseq	uence of):	Preu.	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death 7 9 day
<b>b8 / bU,</b> rtificate be executed ng physician and	he burial-transit	edical Examiner	Sequentially list conditions, it any reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	· · · · · · · · · · · · · · · · · · ·		•			
<b>BOX</b> ath certi	or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	ıldeath 3⊑	Ectopic pregnanc	у		23d. Date Mor	e of delivery nth Day Year
uires that the de	pe q	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the ur	derlying cause giv	en in Part I.		acco use contr s 2 ☐ No	ibute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
OT VITAL RECORDS, Physiclan: The law requires t this certificate has been signe	; page 2 should	Completed						24a. Was ar autops perform 1 □ Yes 2	y p ned? d	Vere autopsy findings available vior to completion of cause of eath?  ☐ Yes 2 ☐ No
OT VITAL P Physiclan: Th this certificate		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ÎNo	lospital: 1 Nnpatient 2 🗆	ER/Outpatien	t 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	h <i>(Ch</i> eck o <i>nly</i> one ome 5⊟ Reside	*	er (Specify)
LIVISION O Il or Attending Ph after death. I Director: After th	by the funeral	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Work 1		28d. Describe ho	w injury occurre	
Spital or nours afte neral Dire	, filled in t		29a. Certifier 1. Oertifying Phys	building, etc. (Special stress) building, etc. (Special stress	owledge, death	occurred at the tir	ne, date and place,	and due to the ca	ause(s) and ma	nner as stated.
To the Hospital within 24 hours a To the Funeral I	completely filled in	Medical	(Check only 2 ☐ Medical Examle one)  29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	ation and/or in	29c. Licens	e number		ed. Date signed	(Month, Day, Year)
			30. Name and address of person who co	1	n 23a) (Type, I	Drint)	24864 bort	<del>/-</del> *	5-10	3-2008
	Stat		31. Date filed (Month, Day, Year)	77 Cupolis 3. Registrar's Signa	ture des	Le Ko	7,00	1 Pet	र्शक्र	MD

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:16 AM **Physician** KAYSAN SHAN TALLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rosedale LTIMORE FRANKLIN SQUEUR HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 40 5/17/08 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F N/A Yrs MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Medical Exact har must be notified at 1 Tes 2 No Director MD BALTIMORE MIDDLE RIVER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 USA 2153 VAILTHORN RD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: ASIAN AMERICAN If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event, If a MER. N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TAHIRA FAROOOI MATTHEW TALLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MATTHEW TALLEY-FATHER 2153 VAILTHORN RD MIDDLERIVER, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 5/20/08 GARDENS OF FAITH BALTIMORE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 21. Signature of Fûneral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part : Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) rematurit 10 min **Physician** /Medical Due to (or as a consequence of): Examiner PROM Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed a resu Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. pe q 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ted Complete 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 KNo 1 ☐ Yes 2 ☑ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00063050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Baltimore 9000 Franklin This matter mo 32. Sgistrar's Signatu 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		for State Registrar	State of Mary		artment of H rtificate of L			g. No.	~ ~	1 00 40 00 0
Physic	cian	1. Decedent's Name (First, Middle,					2. Date of Death Month May 19	7. U	Yeer	3. Time of Death
/Med	lical	Drew Donald Wa  4a. Facility Name (If not institution,	aldron		4b. City, Town, or	Location of Death	May 19	4c. County	of Death	9:12P M
Exam	iner	Casey House	give street and number		Rockville			Montgo		
Funera Directo		402-07-7314	6. Sex 7. Age (In	yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr 9,	Year) 1921	9. Birthpi Goun Arka	ace (State or Foreigr try) nsas
land ow		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				1	Od. Inside City Limits
a-f sh	cto	NM Dona A	nna La	s Cruces						14 Yes 2 No
vith th	Funeral Director	10e. Street and Number	4+0		10f. Zip Code 88007			g. Citizen of \ SA	Vhat Coun	try?
Jeath v	eral	191 Villa Chiqu	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp		14. Rac	e - Americ	
d within 72 hours after death with the Maryland glene. er than "natural", or Items 23a or 28a-f show the Madical Examiner must be notifiled at	by Fur	1 □ Never Married 2 □ Marrie 3 ሺ Widowed 4 □ Divorced	Armed Forces? ed 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		if Yes, specify Cuba 1 ☐ Yes 2K No	Specify:	Hican, etc.)		ok, White, o	
72 hou 'natura dical E	Completed	15. Decedent' (Specify only highes	's Education t grade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of B	usiness/Ind	lustry
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other other	Be Co	17. Father's Name (First, Middle, L	ast)		İ		e (First, Middle, M	aiden Surnan	ne)	<u> </u>
ould by Menta arked	임	James Perry Wal				Celia Sm				
ind 2 sh alth and 27 Is m		19a. Informant's Name/Relationsh James D. Waldro		19b. Mailir 13359	ng Address <i>(Street a</i> Goodhart	and Number or Rur Lane Le	esburg,	VA 201	State, Zip <b>7</b> 6	Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at		20a. Method of Disposition  1 ☐ Burial 2X Cremation  4 ☐ Donation 5 ☐ Other (Sp.	3 Hemoval from State	b. Place of Dispo cemetery, crei hesapeak	osition (Name of matory or other place te Cremato	ory 05/2		oc.Location	-	
permit. Departri	9	21. Signature of Funeral Service I	11 1 1 1 1 1 1 1		Name and Address Sing Home					784 , MD 2102
Medicate pe executed Examine bhysician and st the burial-transit	Examiner	resulting in death)  Sequentially list conditions, if eny, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or as a cor	nsequence of):	-					
death certif e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome pf pr 1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnancy	,		1	ite of delive	ery Day Year
requires that the de een signed by the a hould be detached f	þ.	Part II. Other significent condition	ons contributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
The law ate has b	Completed							/ led? A No	prior to co death?	psy findings availabl mpletion of cause of 2□ No
ng Phys fter this ineral di	tion: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2X No  27. Manner of Death  1X Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier  28b. Time of Injury	of 28c. Injur Wor	er: 4□ Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 🛣 Oti		hospice
after dear Director	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		At home, farm, st pecify)	reet, factory, office		28f. Location (Str. City or Town		ber or Rura	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1XXCertify in 2 1 Medical	g Physician: To the best of my Examiner: On the basis of exa end manner stated.	y knowledge, deat mination and/or in	th occurred at the til	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and mate and plece	anner as s and due t	tated. o the cause(s)
To the I within 2 To the I complet	Me	29b. Signature and title of certifier	1/2/		29c. Licens	e number	29	d. Date signe	ed (Month,	Day, Year)
4		Doven	-/-	N	D646	15	M	ay 20,	2008	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Genevieve Wroblewski, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855								
20		Congrieve Wrohl	ewski, M.D. 60	)01 Munca	aster Mil	1 Rd. Roc	kville.	MD 208	55	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 13 per inf. 2880,06/25/08dhb

Amend Item 31 per dvr., 9879,0772/08dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 723 PM 20 2008 WILLIAM DUIGHT WIARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT Willinder 1 Year CALVERT 7400 COUTET FONDR STONE If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Funeral 1 M 2 □ F Months Days JUNE 23 1927 80 289-20-0764 OHID Director 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number SAINT LEONARD CALUERT 10f. Zip Code 10g. Citizen of What Country? 20685 USA 7400 COURT STONE permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AERONAUTICAL ENGINEER ENGNEEZING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BESSIE MILLEIS DUHN WIARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7400 STONE COURT SAINTLEONARD MA 20685 SPOUSE MARYWIARD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State QUALYSIAM, TUDORAH BUOG CC YAM YSTRIUST 27712 YMOTANA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ANATONY GIFTS PEWSTRY
7532 CONSELLET DRIVE, STEP HANCULT MD 21076 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Colun Physician /Medical Due to (or as a consequence of): metastasis **Examiner** Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: f yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 1 ☐ Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 No 1 Tyes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No I hours after death. death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certifier 08 Prince Frederick, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph John Barth, M.D., Calvert Internal Medicine Group, 110 Hospital Rd 31. Date filed (Month, Day, Year) 32. egistrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 11:20 AM 05 VALERIE WASHINGTON 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner Randallstow Baltimore 410 Place 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗶 F Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modeal Experience, ast the matthed at Randallstow 1 ☐ Yes 2 No **Funeral Director** MD 10g, Citizen of What Country? 10e, Street and Number 10f. Zin Code Hupa Place USA 410 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify <u>۾</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Baltimore court 12th grade 2 yeus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Smothers Diane E. Wright ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, C or Town, State, Zip Code) Hupa Place Randall Stoven M.D 211 Wayne E. Washington Husband 4107 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If iter any injury or oth once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Kidge иd 4 Donation 5 Other (Specify) 22. Name and Address of Facility Name and Address of Facility 21. Signature of Funeral Service Licensee C. Greene Funcial Sives Vauann 8728 Liberry Load KUNDUUSTUUN MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** syncvial sarcoma 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy performed 1 □ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

0,

P.O. Box 68760,

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

KATHERINE



MD

D0061711

05/19

STREET CRBI ROOM 689 BALTIMORE, MD 21231

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician DAVID BENNIE WIRE 11:15P M MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CARROLL FINKSBURG 2030 OLD WESTMINSTER PIKE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 11/25/1926 VIRGÍNIA 220-18-5298 Director 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Musical Examiner must be notified at 1 ☐ Yes 2 X No Director CARROLL FINKSBURG MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21048 USA 2030 OLD WESTMINSTER PIKE items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 窗 Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married "natural", or 1 □ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 Divorced II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Item Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) DRIVER TRANSPORTATION 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEAULA ZELL WRIGHT DAVID BENNIE WIRE, SR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21048 19a. Informant's Name/Relationship (Type. Print) 2030 OLD WESTMINSTER PIKE, FINKSBURG, MD MYRA J. WIRE - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) EVERGREEN MEM.GARDENS 5/22/08 FINKSBURG, MD 21. Si naturo of Firm al Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. MAIN ST., WESTMINSTER, MD 21157 Ε. 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heaft failure. List only one cause on each line. Immediate Cause (Final Physician Mation disease or condition resulting in death) /Medical of Neck 6 month Examiner uamous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has I page 2 s autopsy performed certificate 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

• Funeral Director; A pletely filled in by the fi 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

cai

29a, Certifier

(Check only

29b. Signature and title of ertifier

the

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Baltimore, Maryland 21215-0036

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of Vital Records,

Division

Malcolm

and manner stated.

410 egistrar's Signatu

me and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Drive Suit C

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, ILLIAMSOL 1641 **Physician** 2008 ANNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Genesis Spa Creek Annaoplis 8. Date of Birth (Month, Day, Nov 15, if Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 75 1932 Washington DC 227-36-2466 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other thatmatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Annapolis MD Anne Arundel 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21403 USA 35 Milkshake Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white by 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) back officer financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Taylor Viola Wynder ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrea Curtis/daughger 1742 1742 Wood Tree Circle Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 📉 Donation 5 ☐ Other (Specify) 3 ☐Removal from State icensee 21. Signal are of Funeral S 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street non 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CLEMOSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the The law requires that the death certificate as IF FEMALE esn If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9☐Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 No 3 Probably 4 ☑Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 TYes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: 22 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 42 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To

Division or Vital Records, P.O. Box 68760,

e Hospital or Attending Physician: 24 hours after death.
2 Funeral Director: After this certifical eitely filled in by the funeral director, p completely within 24 the 2

28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of Gertifle 29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Brint)

(IC (+AEL ). Late NTA W) 445 DEFENSE HIGHWAG ANNAPOLIS MO 2140) 30. Name and address

State Registrar

31. Date filed (Month, Day, <sup>Year)</sup>2008

#### 08-03475 Ja

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames A. Walker	State of Maryland / Department of Health and N 1- For State Certificate of Death	Reg. No. 2008 1673
Physician/	Registrar	2. Date of Death 3. Time of Death
ledical Examine	James A. Walker	May 6, 2008
may Sic.	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loci 64 Somers Cove Apt. Crisfield	ation of Death  4c. County of Death  Somerset
Funeral Director	13. Godiai occurity Namber 1171 Pot ook	Hours Min. Sept 27, 1954 9. Birthplace (State or Foreign unk
20	Usual Residence of Decedent  10a State 10b County 10c City, Town or Location	10d. Inside City Limits
ow any	MD Somerset Crisfield	1 Yes 2 No
the Maryland to 28a-f show iffed at once.	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
the Ma a or 28 tiffed a		1817 USA
D 21215-0036 should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once TO Re Completed by Funeral Director	1 Never Married 2 Married Armed Forces? Unk If Yes, specify Cuban, Mi	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
s after ral", o	3 Widowed 4 Divorced if res, Give real	pecify: Specify: black (Give kind of work done unit 16b. Kind of Business/Industry unk
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.  Iant: If iten 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by I	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retired)
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exa	unk unk	
21215-0036 Mot be filed within 7 Montal Hygiene. marked other than c event, the Medica		Mother's Name (First, Middle, Maiden Surname) unk
2121 uld be fill Mental H marked c event,		nd Number or Rural Route Number, City or Town, State, Zip Code)
MD d 2 shoulth and m 27 is aumatin		et Baltimore, MD 21201
ore, Mes 1 and 2 of Health If item 2	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemet crematory or other place)	ery, Date 20c. Location - City or Town, State
Baltimore, bermit. Pages I at Department of He Important: If ite	4 Donation 5 X Other Specify: in state	Codiffy
Baltimore permit. Pages 1 Department of H Important: If i		y Board 655 W. Baltimore Street
Physician	Baltimore, M  23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, su	ch as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
dical standard	failuce. List only orfe cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
	Sequentially list conditions, b. Due to (or as a consequence of):	
led nsit	cause. Enter Underlying Cause (Disease or injury that initiated	
O, e be executed sician and burial - transit	events resulting in death) Last  Due to (or as a consequence of):  d.	
6 be execut burial - tra	UNPENDED	
760, ficate be g physici t the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	23d. Date of delivery  Ectopic pregnancy Month Day Year
Box 6876 e death certificate the attending phy ed for use as the	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
the death certificate by the attending phicked for use as the	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e. Did tobacco use contribute to the cause of death?
P.O.		1 Yes 2 No 3 Probably 4 Unknown
ds, equire een sij		24a. Was an autopsy findings available prior to completion of cause of
Records, P.( The law requires tha ficate has been signed , page 2 should be det		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Rection: The certificate ector, page	b   25. Was case referred to medical	f Death (Check only one)
f Vital Physician: or this certification	Yes 2 No I impatient 2 Erroutpatient 3 Box	ther 4 Nursing Home 5 Residence 6 Other: Scene
Division of Vital Records, pital or Attending Physician: The law require ours after death.  eral Director: After this certificate has been siftled in by the funeral director, page 2 should be a stiff or the funeral director.		at Work?  28d. Describe how injury occurred s 2 No
Sion Attend r death ector: by the	2 Accident S Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office but	Iding, etc. 28f. Location (Street and Number or Rural Route Number, City
Divi	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  1 Vending Natural 5 Pending (Month, Day, Yeár)  28e. Place of Injury - At home, farm, street, factory, office building (Specify)	or Town, State)
8 5 5	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, one and manner stated.  29b. Signature and title of certifier 29c. License	e and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s)
To Too		=
	(almy) ) O.C.M	I.E. May 7, 2008
	30. Name and address of person who completed dause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201
Sta	C D 7/1111X 1 F1454P-40 4 A 7	OCME
Registra	MAY 2 2 2008 Blokue St 1900	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:20 AM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE UNIVERSITY OF MARYLANT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 58 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1⊠M 2□F 49 Yrs Lebanon 294-84-9344 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a.4 ehror 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21704 United States 3936 Loch Ness Court Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 ☑ No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Construction Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Constantina Canarelli Edmond Asmar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3936 Loch Ness Ct. Frederick, MD 21704 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Suad Asmar / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition May 8, 2008 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licenses 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signatur 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Car se (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year for 1 Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 22 No certificate Yes Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 📶 Inpatient Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

0 Division Hospital or Attending within 24 hours after death To the Funeral Director: completely filled in by the

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

8 2008

32. Registra

Registrar

DHMH 17 Rev 1/2001

4 4176435 9 18:43

S. GREENE ST.

29d. Date signed (Month, Day, Year)

CASTLE OF I cial Security Number 79-40-5658 I Residence of Decedent State 10b. Count MD PRIN Street and Number 14711 MT. Clarital Status   Never Married 2 Ma   Widowed 4 Divorce- (Specify only high- ementary/Secondary (0-12) ather's Name (First, Middle VILLIAM HAF Informant's Name/Relation ARSHALL BLE	DOVE NURSING  Son, give street and number)  LOVE NURSING  6. Sex  1 M 2 F 7. Age  7. Age  7. Age  7. Age  7. Age  7. Age  8. CALVERT RD.  12. Was Decedent E Armed Forces? 1 M 2 F 8. Give 1 Yes or Dates:  11 Yes, Give 1 Year or Dates:  12. College (1-4or 5+ 2)  13. Last)  RRISON DICKE	(In yrs. last birthday) 97 Yrs.  10c. City, Town or Loc UPPE  ver in U.S. 13. V	if Under 1 Year Months Days  cation  CR MARLB  10f. Zip Code 2 0 7 7 2  Was Decedent of H f Yes, specify Cuba  1 Yes 2 No  dent's Usual Occup kind of work done to DO NOT use retired	MARLBO  if Under 24 Hrs  Hours Min  ORO  ispanic Origin? ( an, Mexican, Pue  Specify:	RO  8. Date of Bir (Month, De JAN 26)	Day 6 4c. ( PF th 3y, Year) 191	en of What USA 4. Race - Ai	eath  GEORGES  Birthplace (State or Foreign Country)  MD  10d. Inside City Limits 1
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I Residence of Decedent State 10b. County ID PRIN Street and Number I 4711 MT. County I arital Status Never Married 2 Ma Widowed 4 Divorce (Specify only high sementary/Secondary (0-12) I ather's Name (First, Middle VILLIAM HAF Informant's Name/Relation ARSHALL BLE	DICE GEORGES  CALVERT RD.  12. Was Decedent E Armed Forces? 1   1   Yes, Give   Year or Dates:  11   Yes Gue   Year or Dates:  12. Was Decedent E Armed Forces?  1   Yes, Give   Year or Dates:  12. College (1-4or 5+ 2)  2   RRISON DICKE	10c. City, Town or Loc UPPE  ver in U.S. 13. V 16a. Deced (Give life. L	cation  CR MARLB  10f. Zip Code 20772  Was Decedent of H 1 Yes, specify Cube 1 Yes 2 No  dent's Usual Occup kind of work done of the coordinate of the coord	ispanic Origin? (: an, Mexican, Pue Specify:	JAN 26	1 9 1	en of What USA 4. Race - Ai	MD  10d. Inside City Limits 1 □ Yes 2 No  Country?  merican Indian,
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Street and Number  1 4 7 1 1 MT . C  Iarital Status  Never Married 2 Ma  Widowed 4 Divorcee  (Specify only higher  Permentary/Secondary (0-12)  Ather's Name (First, Middle  VILLIAM HAF  Informant's Name/Relation  ARSHALL BLE	Tried 12. Was Decedent E Armed Forces?  I 1 1 1 2 8 2 M N If Yes, Give I Year or Dates:  Int's Education est grade completed)  College (1-4or 5+ 2 RRISON DICKE)	ver in U.S. 13. V	Nas Decedent of H f Yes, specify Cubs I Ves 2 No dent's Usual Occup kind of work done of	ispanic Origin? ( an, Mexican, Puè Specify:	Specify Yes or No to Rican, etc.)		USA 4. Race - Ai	Country?
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Informant's Name/Relation				18. Mother's Na	me (First, Middle	, Maiden S	Surname)	
ARSHALL BLE	ship (Type. Print)	1			LE JOSE			
	EDSOE / SON	1	ng Address (Street a			-		e, Zip Code) 20746
Method of Disposition		20b. Place of Dispos	sition (Name of	i	Date			or Town, State
1 █ Burial 2 □Cremation 4 □ Donation 5 □ Other (	3 ☐ Removal from State Specify)	1	natory or other plac Y CEMET	· .	/8/2008	BE	EALLS	VILLE, MD
Signature of Fuperal Selvio	e Licensee		Name and Addres		HOME			
Ports Enter the disease		P	O. BOX	86, B	ARNESVI		MD	20838
shock, or heart failure. List	or complications that caused to st only one cause on each line	Э.		g, such as cardi	ic or respiratory a	irrest,		Approximate Interval Between Onset and Death
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y, leading to immediate  by Enter Underlying  ce (Disease or injury		consequence of):						
initiated events ting in death) Last	c Due to (or as a	consequence of):						
	d.							
EMALE:								
Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy	,		2	3d. Date of	delivery Day Year
1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5∟	Other (specify)				WOTE	Day Tour
I. Other significant condit	tions contributing to death but	t not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute	e to the cause of death?
DEMENTIA					10	Yes 2	No 3□	Probably 4 Unknown
	-				24a. Was		24b. Were	autopsy findings available to completion of cause of
						ormed? 21 No	death 1 🗆 Y	n? .
Vas case referred to medic xaminer?	Hospital:		Oth					
Manner of Death	28a. Date of Injury	28b. Time of	N 3 DOA	4 Nursing				ipecify)
☐ Accident inves	tigation	rear) Injury						
	mined   Zoe. Place of injul		eet, factory, office				Number or	Rural Route Number,
	ing Physician: To the heet o	f my knowledge death	occurred at the tir	me, date and place	e and due to the	Called(a)	and manne	r as stated
☐ Homicide deten	I Examiner: On the basis of	examination and/or inv	vestigation, in my o	pinion, death oc	curred at the time	, date and	place, and	due to the cause(s)
Homicide deter	ier .	10				29d. Date	signed (Ma	onth, Day, Year)
Homicide determined de	$VI.\Lambda M$	$M \rightarrow$		x / ** /		MAY	7, 2	2008
Certifier (Check only one)  Signature and trie of certifity	COSTI, I							20716
lai	miner?   Yes	mmer of Death Natural 5 Pending investigation Accident Suicide Homicide Sertifier Check only 2 Medical Examiner: On the basis of and manner stating at a figurature and bite of sertifier  me an, ddress of person who completed cause of de	Hospital: 1   Inpatient 2   ER/Outpatient	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other	Yes   Yes   No	Yes   No   Hospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   A Nursing Home   5   Res	Pospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other:   4   Nursing Home   5   Residence   6	Yes   Yes   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (South North, Day Year)   Suicide   Accident   Suicide   Homicide   Homicide   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or City or Town, State)   28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or City or Town, State)   28f. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   29c. License number   29d. Date signed (May 7, 2)   28d. Describe how injury occurred to the cause of the countries of the co

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of Ma	ryland /		rtment of H <i>tificate of L</i>			giene Reg. No.	003	6741
	Physicia	an	Decedent's Name (First, Middle, Las Ferol	E.	Bond	laruk			2. Date of De Month May 4,	Day	Year	3. Time of Death 3:09 p M
-	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	20110		4b. City, Town, or	Location of Death		4c. Coi	unty of Death	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	nplace (State or Foreign
b.	Director		219–12–4009 11 Usual Residence of Decedent	□ M 2 <b>X</b> F	82	Yrs.	Monard Baye	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dec. 2	<b>5,</b> 192	25 Ma	arýland
	Maryland -f show	tor	10a. State 10b. County Maryland Anne Ar		10c. City, To	own or Loc	ation Annar	∞lis				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a	Il Director	10e. Street and Number 1325 Washington	Drive			10f. Zip Code	21403			of What Cou	
036	within 72 hours after death with the Maryland glee. "than"natural" or items 23a or 28a-f show It a Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 🗷 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☒ No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □Yes 2X No	ispanic Origin? (Sp nn, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: Wh	, etc.
က်	72 inal	Completed	15. Decedent's Ed (Specify only highest grade	ucation de completed) College (1-4or 5+		6a. Deced (Give I life. D		ation during most of work f)	ing		of Business/I	
	a the H	a)	12 17. Father's Name (First, Middle, Last)				Auditor	18. Mother's Nam		, Maiden Sui		aryland
Maryland	0 # D 0	To B	Sylvester E. Tan						beth Ke		Ctate 7	Un Codo
Mar	ind 2 should alth and Mer 27 is marke er traumatic		19a. Informant's Name/Relationship (7 Rhonda Bondaruk/		1			and Number or Ru n Road A				21403
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		20a. Method of Disposition  1XX Surial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify				sition (Name of natory or other place ff Cemete	e) ;	Date 2008		ion-City or ionlis,	Town, State Maryland
Baltı	permit. Departm Importa any Inju		21. Signature of Fundral Service Licen		<del>ا</del> س	- 1		ss of Facility Jo f Glouces		_		al Home , MD 21401
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that caused one cause on each line	€.				or respiratory a	arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a			colon co	ancer				5/07
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	bDue to (or as a	consequen	ce of):						
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequen	ce of):						
8/60,	icate be physicia the bur	dical		d								
O. Box 6	t the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 42 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth of 1 □ Pregnant at 9 □ Unknown	2 🗌 Fetal de	ath 3 🗆	Ectopic pregnanc Other (specify)	у		230	I. Date of del Month	ivery Day Year
S, P.	es tha igned be de	ρ	Part II. Other significant conditions of					en in Part I.				the cause of death?
Division of Vital Records,	e law requir has been si ie 2 should I	Completed	per pheral	rescule	- di	va	۲۷		24a. Was	an 2	24b. Were au	stopsy findings available completion of cause of
Tal F	stcian; The Is certificate ha rector, page 2	Be Con	25. Was case referred to medical					26. Place of Dea		ormed? 2 No one)	1 Yes	2 🗸 🚾
<u>&gt;</u>	hysici this cer al direc		examiner?				oth	4 LI Nursing n	ome 5 Res			cify)
ono	nding F ath, r: After e funera	ation:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	now injury o	ccurrea	
Oivis	I or Atte after dea Directo I in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	, farm, str	eet, factory, office		28f. Location City or To	(Street and N wn, State)	lumber or Ru	ıral Route Number,
_	To the Hospital or Attending Physician: in 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	dge, death	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the erred at the time	e cause(s) ar , date and pl	nd manner as ace, and due	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier				29c. Licens	- 0		4 .		h, Day, Year)
			Nasaper					7070		rre	127	2008
	100		30. Name and address of person who	- S+ B4	1/2	sore	mD	Dan Lah				
	Sta		31. Date filed (Month, Day, Year)	2. Registra	ar's Signature							
	Registr	ar	MAY 0 7 2008	Plase	J.	A STATE OF						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death BRAUW Year Month MAY **Physician** 13 P M OHN 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Hedical Center Glen Busnic A.A. MI Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) MD 6. Sex Days 1 M 2 ☐ F 214-44-8248 MD 6 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 USA Funeral 8526 Brauns Ave. 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 Mg Yes 2 □ No Vietnam If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2K Married White 1 ☐ Yes 2 No Specify Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Co. Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hermine Rehder George Braun ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8526 Brauns Ave. Severn, MD 21144 Susan P. Braun Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 5/12/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Sall 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final an lestive Y-1 resulting in death) Re Hauy Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 4 Unknown robably Completed Cardinoscolo- disense Athensclentic 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform COPI 2 No 1□ Yes 2XNo 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

P.O. Box 68760

death certificate be executed attending physician a ed by the a detached for signed by to Division or Vital Records. been has page certificate director, this funeral After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. filled in by the

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

Examiner

and

/Medical

Maryland 21215-0036

Baltimore,

ledical Registrar

29b. Signature and title of certifier

6 ☐ Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ompieted cause of death (Item 23a) (Type, Print)
1417 Madison Park Drive Cleu Burnic Mi) 2106/ AIZLLO

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

MAY 0 7 2008

32 Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 18 2008 6:05  $A^M$ May Harold Eugene Burkett Jr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 x M 2 □ I 62 Director 220-42-6156 August 15, 1945 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10b. County 1 ☐ Yes 2 No Director Frederick Thurmont Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21788 "natural", or items 23a 6830 Kelly Store Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: white ģ 3 Widowed 4 Divorced Year or Dates er than "nature, the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Construction Worker Construction 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be rent of Health and Mental Goldie Ednia Baugher Harold Eugene Burkett, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Martha Burkett / Sister 6830 Kelly Store Road, Thurmont, Maryland 21788 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò May 19, 2008 Smithsburg, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause this last of that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐Live birth Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Yes Records, P.O. the 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Dunknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas page 2 s autopsy performed certificate | 2 Ato Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Yes 2 AV 1 1 Impatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No hours after death 2 Accident nin 24 hours after death the Funeral Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Seventh Street, Frederick, Maryland 21701 Lamont Charles Smith M.D. ¿32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** AQUELIN 8 Z008 /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1947 MAIN AVE ASADENA If Under 1 Year If Under 24 H SUDEC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 🖫 F Days Months Hours Min. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Jown or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23e or 28a-f ahow ury or other traumatic event, It a Medical Examiner must be notified at 1 ☐ Yes 2 TMO Director ADEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ,5 OA . Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ⋧ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EDRAR WATSON 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARNETTE, HUSBAND KADENA, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) REMATURY 5 f Sey ce Lic nsee 21. Signatur Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122

Po not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the upper shock, or heart failure. List only one because in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician SCLENUSIS AMOTROPHIC LATERAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown Ś Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTN, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 2 No 1 ☐ Yes of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one a No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation after death. 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital 24 hours a Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of

31. Date filed (Month, Day, Year)

ARNOLD,

mi

who composed cause of death (Item 23a) (Type, Print).

32. Registrar's Signature

Beninsula

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

December of Present Processing				For State Registrar	State of Mi	aryland / L		tificate of			-	Reg. No.	2008	.6/40
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Former Interest to the property of the propert											April	_		10:00
Found   Foun		Examin	er	,										
Signature   Sign		Funeval				e (In yrs. last bir	rthday)	If Under 1 Yea	r If Unc	der 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign
The State   10c. County   10c. City   10	N.			412-24-4766	1 <b>∑</b> M 2□F	89	Yrs.	Months Days	Hour	s Min.	Nov. 2	.8, 1	918 Ind:	ianapolis,IN
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Physician (Modical Examiner    Physician (Modical Examiner   Physician (Modical Examiner)	g	permi Depar impor any Ir		21. Signature of Funeral Service Lic	ensee	/								
Physician Medical Examiner    Part   Physician   Physi	r	4		23a. Part1. Enter the disease, or co	mplications that caused	the death. Do							Liig Coir,	
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Section   Sect	J.	that the ed by detac			contributing to death b	out not resulting i	in the u	nderlying cause (	given in Pa	art I.	23e. Did	tobacco u	use contribute to	the cause of death?
Section   Sect	rds	quires nn sign uld be									1 🔀	Yes 2	□ No 3 □ Pr	obably 4 □Unknown
25. Was case referred to medical examiner?  1   Yes 2   No   Normal    26. Place of Death   Check only one    27. Manner of Death   1   Normal    28. Date of Injury   28. Date of Injury    29. Date of Injury   28. Date of Injury    29. Date of Injury   28. Date of Injury   28. Date of Injury    29. Date of Injury   28. Date	Keco	The law rete has bee	omplet								auto perf	opsy ormed?	prior to death?	completion of cause of
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State Registrar  NAY 0 7 2008  State Registrar		6x1		•	•				Daniel Daniel	thord-	MD			
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State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death

A 100
Physician
/Medical
Examiner
Funeral
Director

1 - For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. Ifter death.

To the Funeral Infector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

ın	Tal	hn Mich				May	04	200					
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er			ara manibory		12. 3.0,, 13								
	801 Ede1b1u  5. Social Security Number	6. Sex	7. Age (I	n yrs. last birth	hday) If Under 1 Ye	Silver ar   If Unde		8. Date of Birt	Montgomery irth 9. Birthplace (State or Fore				
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	Usual Residence of Decedent		1/	Dc. City, Town	or Location						10d. Inside Cit		
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n n	11. Marital Status	Arn	is Decedent Evened Forces?	er in U.S.	13. Was Decedent of If Yes, specify C	uban, Mexic	an, Puerto F	Rican, etc.)		Black, Whi			
by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Y	]Yes 2 ▼ No ′es, Give ar or Dates:		1 ☐ Yes 2 <b>区</b> 1	No Specify	y:			Specify:	Caucasia		
	15. Deceden	nt's Education			l Decedent's Usual Oc				16b. Kin	nd of Business	/Industry		
Completed	(Specify only higher Elementary/Secondary (0-12)	st grade comp	llege (1-4or 5+)		(Give kind of work do life. DO NOT use rei	ne during mo ired)	ost of workin	g					
E O	Elementary/Secondary (S*12)		2		Sales	Manage	er			Ins	urance		
BeC	17. Father's Name (First, Middle,	Last)				18. Moti	her's Name	(First, Middle,	Maiden S	Surname)			
다 E	John	Corrado					K	atie Lucy	y Pasc	quale			
T)	19a. Informant's Name/Relations	ship (Type. Pri	int)	19b.	Mailing Address (Str.	eet and Num	ber or Rura	Route Number	er, City or	r Town, State,	Zip Code)		
3	Charleen Corrad	o - Wife			801 Edelblut	Drive,	Silve	r Spring	, Mary	yland 20	901		
	20a. Method of Disposition  1 🕱 Burial 2 🗆 Cremation	3 □ ₽			Disposition (Name of y, crematory or other		D	ate	20c. Loc	cation - City or	r Town, State		
	4 □ Donation 5 □ Other (S		a nom state	Gate of	Heaven Ceme	etery	05/08	/2008	Sil	ver Spri	ng, Maryl		
	21. Signature of Furieral Service	Ligensee	<u> </u>	_	22. Name and Ad Hines-Rina			omo Tne					
	Jary	mi	pri		11800 New	Hampshi	re Ave	nue, Sil	ver Sp	pring, M	aryland 20		
	23a. Part1. Efter the diseas	rcomplications	s that caused the	e death. Do n	ot enter the mode of	dving, such a	as cardiac o	r respiratory ar	rest		Approximate		
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final										Interval Bety		
		only one caus				,		respiratory as	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Bet Onset and D		
	Immediate Cause (Final disease or condition resulting in death)	a	Pancreati	ic Cancer				roopii alory al	7001,		Interval Bette Onset and E		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:37 P M May 3, 2008 Francis Joseph Cucurullo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days Hours 1 X M 2 □ F 56 090-46-9652 Dec 7, 1951 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Director MDMontgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 United States 16620 Music Grove Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 🛛 No Specify: White Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Park Elementary/Secondary (0-12) College (1-4or 5+) Service Park Ranger-Historian 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Constantine Salvatore Cucurullo Kathryn Schott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16620 Music Grove Court Rockville, MD 20853 Karen L. Cucurullo (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 08. 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐Removal from State Metropolitan Crematory 2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 RACI sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Minutes Acute Cardiac Arrest

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760

**Funeral** 

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

traumatic event, the Medical

Department of Health a Important: If item 27 is any injury or other tra once.

Physician

/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

altimore, Maryland 21215-0036

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Completed					performed	? death?	s 2□No
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ation: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
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dical C	29a. Certifier 1 X Certifying Ph (Check only one) 1 Medical Exam	nysician: To the best of my knowniner: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier	Ma	11 2	9c. License number	29d.	Date signed (Mor	nth, Day, Year)

12

or mis 31. Date filed (Month, Day,

050410

29d. Date signed (Month, Day, Year)

May 06, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince Phillip Drive, Olney, MD. 20832

State Registrar 0



State of Maryland / Department of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001

State

ROST, SGAH,

31. Date filed (Month, Day, Year)

Registrar's Signature

P.O. Records, Division or Vital

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State

29b. Signature

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Registrar

DHMH 17 Rev 1/2001

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and address of person who completed cause of death (Item 23a) (Type, Print)

4410 Backelons Pt. Rd. 0+pinD, MO 21654

			For State Registrar	State of M	laryland /	-	artment of F		and Menta		iene	102	• 6	750
-	*	4	Decedent's Name (First, Middle, Language)	ast)						ite of Deat		Year	3. Time of	Death
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	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Las	t)					er's Name (First,			,		
	d Mer narke	유	Albert Lee Amoss  19a. Informant's Name/Relationship		111	Ob Maili	ng Address (Street		Virgini				in Code)	
	th and the strain traur		Karen Alexander,				Bolton Bi							2627
<b>5</b> - 5	other trau		20a. Method of Disposition		20b. Place		osition (Name of matory or other pla		Date		20c. Location			2027
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Į	+		30 Name and address of person wh	aminer: On the basis and manner:  4D  o completed cause of Ikhani  0 8 2008	f death (Item 23	a) (Type	Print)	n.	TIL P	~ L	, n	NV.	201010	,
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2003 **Physician** May 2332 Norvell M. Dennis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 17 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. Maryland 1946 216-44-6171 Apr Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a ~ ~ ~ any injury or other traumatic event. It is a marked once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Churchton Maryland Anne Arundel 1 ☐ Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20733 USA 1210 Sugar Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 No If Yes, Give Year or Dates: 1 968-69 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ∐Yes 2 📆 No Specify. ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Operator Westinghouse 12th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Dennis Sr Dorothea Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Sugar Lane Churchton, Md. 20733 Gertrude Dennis(Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dennis-Griffin Cem 5-9-08 Shady Side, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Brances of cilions Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Physician 13 chemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician Box 68760 Completed by Physician/Medical as the attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy performed? Yes 2.☐No 1 ☐ Yes 2 ☐ No 1 □Yes 25, Was case referred to medical examiner? After this certific funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending To the Hospital or Attendin. within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and #tle of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen 31. Date filed (Month, Day, Year) egistrar's Signature MAY 0 7 2008 Registrar

DHMH 17 Rev 1/2001

08-03592 Clayton Lloyd Duna	agan	Pleas		or Print e of Mary									egibl	e.			
	1- For Star Registrar	te	-			Certific					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Reg. No	. 00	3 000	1 -7 -7	
Physician/ Medical Examiner	an/ 1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day May 11, 2008													O020 hrs			
ويبارغ	4a. Facility Name (if not institution, give street and number)  Calvert Memorial Hospital  4b. City, Town, or Location of Death Prince Frederick  Calvert											Death					
Funeral Director												9. Birthplace (State or Foreign Country) Maryland					
land fshow any pnce.	10a State	and C	County alver	t	100	c. City, Town Barst										10d. Inside City Limits  1 Yes 2 X No	
the Maryland as or 28a-f sh otified at one		et and Number Hallo	wing	Point R	oad			10f, Zip ( 206	10					tizen of Wh ted S			
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hault and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	3 Wi	ever Married idowed 4	Divor	Armed 1 Yes ced If Yes, Give Yor Dates:	'өөг	No	1	es, specify Yes 2	Cuban, I X No	Mexican, specify:	Puerto Ri			White Specify:	14. Race - American Indian, Black, White, etc.  white Specify:		
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam	15. Dece	edent's Educat ntary/Secondar 2		only highest g	(1-4 or 5+)		during m	t's Usual Cost of work	ing life. D					. Kind of Bus Buildi	dustry		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple		r's Name (Firs 1 Mell	t, Middle, La Dunag	ast) an					J	ean 1	Elois	se St	affc		ı Surname) rd		
MD 21 d 2 should th and Mei n 27 is mad aumatic ev	19a, Infor	mant's Name/i 1 S. Du	Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City  P.O. Box 32 Barstow, Maryland 200										City or Town, State, Zip Code) 20610				
Baltimore, I bernit. Pages I and Department of Heal Important: If item njury or other tran	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, May 14 200 8 Alexanders)  Method of Disposition (Name of cemetery, May 14 200 8 Alexanders)										Location - City or Town, State Alexandria Virginia						
Balt permit. Departi Import injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home											D 20676					
Physician /Medical 	failu Immediat	I. Enter the dis re. List only on te Cause (Fina ion resulting in	ne cause or I disease	omplications that n each line. a. <u>Chron</u> Due to (or a	ic obst	ructive						respiratory	arrest, s	hock, or hea	art	Approximate Interval Between Onset and Death	
ecuted and transit al Examiner	Sequentia if any, lea cause. E (Disease events re	ally list conditionaling to immediate Unidentification or injury that insulting in deat	liate y Cause nitiated	b													
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P.O. Be res that the designed by the a be detached for a by Phys	3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							rt I.		the cause of death?						
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for usedical Certification: To Be Completed by Physic	_			··.s =	<del></del>							pe	as an atopsy erformed es 2	[? ]		topsy findings available completion of cause of ss 2 No	
tal F cian: certific certific ector, g	25. Was	case referred t	o medical	11				2		of Death (	(Check or	nly one)					
f Vit Physic er this er ral dire	1 🗸	Yes 2	No	Hospital: 1			Dutpatient				, •	Home 5		idence 6	Other	:	
sion of ttending death. ctor: Afte y the funer	1 X N	2 Accident Investigation							No	28d. Describe how injury occurred							
Division o Hospital or Attending 24 hours after death Funeral Director: Aftered filled in by the fune al Certification:	3 S 4 H	Suicide 6	Could determ	ined (Spec	fy)	y - At home,						or Tow	n, State	)		ral Route Number, City	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page Medical Certification: To Be Com		<sub>2</sub> Med	dical Exam	sician: To the iner:On the bas and manne	is of examin	nowledge, do	eath occu investiga	tion, in my	opinion,	death oc	curred at	the time, d	ate and	place, and o	due to th	e cause(s)	
Ž	29b. Sigr	nature and title	of certifier					290	License O.C.N					d. Date sigr lay 13, 20		nth, Day,Year)	
	10	e and address Rubio MD		tant Medica				Street, B	altimo	re, MD	21201						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feryal Wassef Dawad May 13 2008 8:15 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1969 Constitution Drive Calvert St. Leonard 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 1 M 2 F 67 214-41-4474 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Calvert St. Leonard 1 □Yes 2XINo Director 10e. Street and Number 1969 Constitution Drive 10f. Zip Code 20685 10g. Citizen of What Country? Egypt Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc 1 Never Married 2 Married Specify: Egyptian 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) Wedad Malaty 17. Father's Name (First, Middle, Last) Wassef Dawad Be 19a. Informant's Name/Relationship (Type. Print) Nasry Estafanos Londy— husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1969 Constitution Drive St. Leonard MD 20685 20b. Place of Disposition (Name of Fairly, crematory or other place) Fairly Memorial Park 20a. Method of Disposition Date May 15 2008 1 Burial 2 □ Cremation 3 ☐ Removal from State Fairfax, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Euneral Service Licensee Stawal 4405 Broomes Is. rd. Port Republic 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOLANGIOC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy

Physician /Medical Examiner

Examine

Medical

(Check only one)

29b. Signature and title of certifier

permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Medic once.

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial physician the use for à signed t been sign has page certificate After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

that the death certificate be executed

Hospital or Attending

Division or Vital Records, P.O. Box 68760,

dical		_d				
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I,	23e. Did tobacco u	use contribute to the cause of death?
ed by	DEEP VEINT	1 □ Yes 2	Mo 3 Probably 4 Unknown			
plet	SEPS1S	24a. Was an	24b. Were autopsy findings available			
Completed					autopsy performed? 1∐ Yes 2 2 300	prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		ath (Check only one)			
일	1 ☐ Yes 2 Dolo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 [	OOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)
	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, facto fy)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, e)
	29a Cartifier 10 Cartifying Ph	veician: To the hest of my kno	wledge death occurre	d at the time, date and plac	o and due to the source/s	and manner or stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D0062100

29d. Date signed (Month, Day, Year)

AY 14,2008

State Registrar

Dung Le 1650 Orleans Street, Room 407 Baltimore, Maryland 21231 31. Date filed (Month, Day, Year) MAY 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

				aryland / De 8a-f per	partment me 9884 eriticate	of Health	and Mental Hy 08dhb		18 1.67.54	
Physicia /Medica Examine	ai	Decedent's Name (First, Middle, La     L	H day	I. E	LEY 4b. City, To	own, or Location	2. Date of D Month Of Death	Day  5  4c. Coupty	Year 821P M	
Funeral Director	ð : 5,	213-30-0022	DOL NED ex PORM 20 F	7) CAL (In yrs. last birtho 73 Yrs	ay) If Under 1	1	Transor	inth ay, Year) 8, 1934	9. Birthplace (State or Foreig Maryland	
Maryland	ctor	Usual Residence of Decedent  10a. State  Maryland  Anne A	rundel	10c. City, Town o	r Location	Annap	olis		10d. Inside City Limit:	
h with the 23a or 28	al Dire	10e. Street and Number 123 Severn Avenue	9		10f. Zip C	2140	3	10g. Citizen of V	·	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be routiled at once.	Completed by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	ło	13. Was Decede If Yes, specif		rigin? (Specify Yes or N an, Puerto Rican, etc.) /:	Blac	e - American Indian, ck, White, etc. y: White	
filed within 72 ho Hygiene. other than "natur ent, ine Medical	ompleted	15. Decedent's E (Specify only highest grades) Elementary/Secondary (0-12)		(0	ecedent's Usual Bive kind of work te. DO NOT use Engin	done during mo retired)	st of working		usiness/Industry neering	
ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last, Clifford Hamdo					ner's Name (First, Middle trude Herri		пе)	
1 and 2 should Health and Men em 27 is marke wher traumatic		19a. Informant's Name/Relationship ( Barbara Eley/wi					oer or Rural Route Number Annapolis			
Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition  1 Burial Coremation 3 4 Donation 5 Other (Special		cemetery,	isposition (Name crematory or oth ore Crem	er place)	Date 5/8/2008		city or Town, State	
permit. Pag Depertment Important: any injury o		21. Signature of Funeral Service Lice	- Til	Jen				_	uneral Home olis, MD 21401	
Physician /Medical Examiner	_	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  ASPIRATION PNOUNONIA  Due to (or as a consequence of):							Approximate Interval Between Onset and Death HOURS	
eath certificate be executed attending physicien and for use as the bunat-transit	ilcal Examiner	CERTIFICATION OF CERTIF							, ms	
law requires that the death certificate be execut as been signed by the attending physicien and 2 should be detached for use as the burial-tran	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 Ectopic pred			1	ate of delivery onth Day Year	
w requires that the dibeen signed by the should be detached		Part II. Other significant conditions of END STAGE PO	WAL DI	SOASA	~	use given in Part			tribute to the cause of death?  3 Probably 4 Unknow	
The ste h	Completed by		PAILU RESIS	Re.			per 1 Yes	formed?	Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
hysicie his certi	To Be	examiner? 1 A Yes 2 No	Hospital: 1 ☐ Inpatie			Other: 4 🗆 N	ce of Death <i>(Check only</i> Jursing Home 5 🗆 Re		ner ( <i>Specify</i> )	
Attending Physicien: r death. ector: After this certific by the funeral director.	catlon:	27. Manner of Death    Tanatural   5   Pending     2   Accident   investigation     3   Suicide   6   Could not be		Year) 28b. Tin Inju	lown M	o. Injury at Work? <b>Unk</b> 1 1 ☐ Yes 2 ☐	nown 28d. Describe Unkno	how injury occur	rred	
i Die	Medical Certification:	4 Homicide determined	building, etc		Unknown		City or To	ocation (Street and Number or Rural Route Number, ity or Town, State) <b>Unknown</b>		
To the Hospitel within 24 hours in To the Funeral completely filled	edical	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/	death occurred a or investigation, i	t the time, date a n my opinion, de	and place, and due to the ath occurred at the time	e cause(s) and m e, date and place,	anner as stated. and due to the cause(s)	
To t To t com	Σ	29b. Signature and title of certified	1. Ah	MO		D46 Z	360	29d. Date signe May	ed (Month, Day, Ygar) 6, 2008	
IO D	te.	30. Name and address of person who NICHNEL	MIKRON	eath (Item 23a) (Ty 1 SO) ar's Signature	VeTOR	ans/416	HWAY N/	ILLPRSVI	ue MD ZIK	
Registra	ar	MAY 0 7 2008	Blow.	& Som	le		/			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 12:11 P 5/04/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□ F 50 027-50-8212 Director 06/15/1957 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any luny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | Montgomery Takoma Park 1 X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 20912 United States 8306 Haddon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physicist Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward S. Gushue Marion Murphy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia J. Decker / Wife 8306 Haddon Dr. Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other procedure) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 X Removal from State 5/10/2008 Coram, New York 4 ☐ Donation 5 ☐ Other (Specify) Washington Memorial 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 Part1. Enter the disease shock, or heart failur , or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one can be on each line. Immediate Cause (Final disease or condition resulting in death) Physician andi Due to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specity) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy 1∐ Yes 2 👿 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ☑ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ..
completely filled in by the f 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 KG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year,

MAY 07

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** R. Green 6:00 p<sup>M</sup> April 24, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6 Thorburn Court Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F January 23,1950 California 164-40-1224 58 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene at the strength and Mental Hygiene attended to the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 6 Thorburn Court 20878 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates: 971-1979 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ E No ģ Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Computer Industry Pages 1 and 2 should be filed nent of Health and Mental Hygint: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harris Roy Green, Jr. Frances Louise Trubey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joan Green-Spouse Thorburn Court, Gaithersburg, MD 20878

f Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of important; If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory May 6, 200\$ Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Lifensee 1040 ROckville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Progressive Supranuclear Palsy disease or condition resulting in death) 5 Years /Medical Due to (or as a consequence of): Examiner Parkinsonism Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5-Years Due to (or as a consequence of): Examiner be executed sician and burial-trans Due to (or as a consequence of): ₹. P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown þ page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MLL INONUS Division or Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 1∐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/29/2008 MD30358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

MAY 0 7 2008

Fernando Pagan, M.D.,

31. Date filed (Month, Day, Year)

3800 Reservoir Road, NW, Washingotn DC, 20007-2113 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month y 7, **Physician** 2008 **GORDON** May 12:15 A.M Bertha /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MOntgomery General Hospital 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Oct. | 2, 9. Birthplace (State or Foreign Country)
Philadelphia, 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛚 F 577-42-8285 95 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.

mit; if item 27 Is marked other than "natural", or items 23a or 28a-f show int, or other traumatic event, if a Modes Examine train to route. 1 XYes 2 No Director DC None Washington, DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20011 USA 1421 Rittenhouse St., NW Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**Y**∏No ģ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Rossin Sallv Glickman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Canyon Rd., Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type. Print) Arlene Balaban / daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot N Burial 2 ☐ Cremation 3 ☐ Removal from State May 9, 2008 Adelphi, MD Mt. Lebanon Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fun eral Priving Licens 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** now mygard /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
Funeral Director; After this certificate has been signed by the attending physician and the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 🗆 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a TCertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

M 50 + 6 Registrar's Signature

2008

			1 - For State Registrar	State of Maryla	nd / Dep		Health and	Mental Hy	_	16758
	Physic /Medi		1. Decedent's Name (First, Middle, Las. Barbara Ann Gre					2. Date of De Month May	Day Year 4 2008	3. Time of Death 10:58 PM
	Examir		<sup>4a. Facility Name (If not institution, give</sup> Anne Arundel Medi	street and number) cal Center			or Location of Dea	th	4c. County of Death	Arundel
	Funeral Director		5. Social Security Number 6. Se 579-56-6038	7. Age (In yrs		Months Days				nplace (State or Foreign Intry) rginia
	Maryland s-f show ified at	tor	10a. State 10b. County Maryland Anne A		ity, Town or Lo		napolis			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	th with the 23e or 28 at be not	Funeral Director	10e. Street and Number 506 Tulip Road			10f. Zip Code	21403		10g. Citizen of What Co. U.S.A.	untry?
036	Swithin 72 hours after death with the Maryland piene. I than "natural", or Items 23e or 28e-f show the Marileal Evan Marileal at the Marileal Evan Marileal at the Marileal Evan Marileal at the Marileal Evan Marileal at the Marileal at the Marileal at the Marileal at the Marileal at the Marileal at the Marileal at the Marileal at the Marileal at the Marileal Evan Marileal at the Marilea at the	b	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:	J.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (s ban, Mexican, Puel o Specify:	Specify Yes or No rto Rican, etc.)		
Maryland 21215-0036	77 - 1 -	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retir Homema]	e during most of wo ed)	orking	16b. Kind of Business/l	•
yland	a filed I Hyg othe /ent,	To Be C	17. Father's Name (First, Middle, Last) Aaron Archer	-				me (First, Middle, ine Lang	, Maiden Sumame)	
Mar	nd 2 sho alth and 27 Is mu rr trauma		19a. Informant's Name/Relationship (T) Fred Gregory/husl				et and Number or A ad Annap		er, City or Town, State, Z ryland 214	
Baltimore,	Pages 1 a lent of He. nt: If item ry or othe		20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	TOTTO STATE		osition (Name of matory or other plants Ce		Date /2008	20c. Location - City or 1  Arlington,	
Balti	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signature of Poneral Service Licens		2:	2. Name and Addr	ess of Facility J	ohn M. T	aylor Funera , Annapolis	al Home
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Sepsis  Due to (or as a conse	quence of):	Diffi		c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect.						
. Box	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6 9 Unknown	al déath 3[	□Ectopic pregnand □ Other (specify)	су		23d. Date of deliving Month	very Day Year
rds, P	sigr d be	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contribute to Yes 2□No 3□Pro	the cause of death?
		Completed						24a. Was autor perfo 1 \( \text{Yes} \)		opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	3500		hon	ath (Check only o		
on of	After After fune	H-14	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Ampatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	4   Nursing a		dence 6 Other (Spec how injury occurred	fy)
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, sti fy)	reet, factory, office		28f. Location (S City or Tox	Street and Number or Rui vn. State)	ral Route Number,
	n 24 hour: n 24 hour: ne Funera	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier	f mo		Ì	se number 585 ( (	_	29d. Date signed (Month May 5, 200	, . ,
	50		30. Name and address of person who of Stephen				2001 Medi Annapolis			11
P	Sta Registr	ite	31. Date filed (Month, Day, Year)  MAY 0 7 20	32. Pegistrar's Sign	ature	Carlo				

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: death. within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar DHMH 17 Rev 1/2001

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 ☐ Could not be

AHMAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

M.D

3 ☐ Suicide

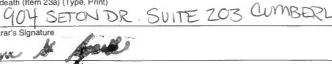
29a. Certifier

Medical

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D60478

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend 17 per B cert. g879 OS/22/408 oktreath Reg. No. 2. Date of Death Day Year Month Physician 1800 03 3008 4a. Facility Name (If not institution, give street and number) 63 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Balhmore 13altimurc er 1 Year | If Under 2 Sina Hospital 8. Date of Birth (Month, Day, Year) Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1□ M 2 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No altimore MID Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AIG NIA AIG AIG 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 10 wax Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip de) 19a. Informant's Name/Relationship (Type. Print) Hother Avenue Bato, MD, 21215 11ta 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 08 Important: If It any injury or c 1 ☐ Burial 2 ☐ Cremation 3 Removal from State HOSPITAL 4 □ Donation 5 Other (Specify). Ho501TAL 22. Name and Address of Facility Sivai A 21. Signature of Funeral Service Licensee DISDOSAL Beluepere Au MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical ası IF FEMALE: If yes, outcome pf pregnancy

1 ve birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Stive birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) P.O. 1 2008 23 detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, by No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an autopsy this certificate has Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check onl. one Be Other: Hospital: 2N No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 funeral 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: Injury Naturai Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and more of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401W Belvenece Ave. BALTIMOR Sirai Hospital Dr. McNeal-JULKSON 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2 2 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:50 AM 2008 May 3, William Otis Howland /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Manor Care Nursing Home Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birth place (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☑ M 2 □ F Days 1925 Cleveland, OH 30, 82 Director 297-16-6180 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 8how is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was 23 or 28e-1 show items 23 or 28e-1 show titems 27 le marked other then "natural", or Items 23a or 28e-1 show to other treumatic event, Item Mexical Event action to the reamatic event, Item Mexical Event actions to the present the mexical factors. 1X Yes 2 No Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6312 Carnegie Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1944-46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martha Carolyn Walker Homer Lawrence Howland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 Bralan Ln. Gaithersburg, MD 20877 Phil Howland / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Importent: If it
any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. May 9, 2008 Crownsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Fuperal Service Licensee inche 7400 Georgia Ave., N.W. Washington, D.C. 20012 msaar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALLURE **Physician** TETRIVE /Medical Due to (or as a consequence of): Examiner DIAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed physician and strans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medicai attending physical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No page 2 s 2 NO To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Ratural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 🗌 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Pars, MO 00057124 1510V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Truong Bao 9715 Medical Center Drive, Suite 201 Rockville, MD 20850 31. Date filed (Month, Day, Year) State MAY 0 7 2008 Registra DHMH 17 Rev 1/2001

		For State of M. State	aryland / Depa <i>Cei</i>	artment of He <i>rtificate of D</i>			giene Reg. No. 2 A A B B B B B B B B B B B B B B B B B
Physic		Decedent's Name (First, Middle, Last)  Ruth Learn	Hersker			2. Date of Dea Month May	3. Time of Death 4, 2008 7:35 P. M
/Med Exam		4a. Facility Name (If not institution, give street and number)	Hersker	4b. City, Town, or 1	ocation of Death		4c. County of Death
,		9 Chestnut Street, # 412 5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthday)	Gaither  If Under 1 Year	sburg If Under 24 Hrs.	8. Date of Birt (Month, Da	Montgomery  9. Birthplace (State or Foreign
Funera Directo		100-26-6553 <sup>1□ M 2</sup> TF	86 Yrs.	Months Days	Hours Min.	Month, Da	y, Year) Couintry) , 1921 PA
ryland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo		-		10d. Inside City Limits 1
e Ma 3a-f s	양	MD Montgomery	Gaith	ersburg			
with the	Il Dire	10e. Street end Number  9 Chestnut Street #412		10f. Zip Code 20877			10g. Citizen of What Country? United States
<b>BAITIMORE, IMARYIGATIO ZIZIO-UUSO</b> permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lightry or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2☒ If Yes, Give Year or Dates:	No.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Spanic Origin? (Spanic Origin), Mexicen, Puerto	ecify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Z1Z15-UU36 d within 72 hours af giene. er than "natural", or , the Medical Examl	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	edent's Usual Occupa e kind of work done do DO NOT use retired)	uring most of work	ing	16b. Kind of Business/Industry  Health and Human Services
A wij	ပ္ပြ	2		Nurse		450	
d be file ental Hy ked oth	To Be	17. Father's Name ( <i>First, Middle, Last</i> )  Harvey Learn			18. Mother's Name Emma Ho		, Maiden Surname)
Maryland nd 2 should be file slith and Mental Hy 27 is marked oth	F	19a. Informant's Name/Relationship (Type. Print) Susan Rubinstein/Daughter		ing Address (Street a			er, City or Town, State, Zip Code) 20850
Baltimore, permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other		20a. Method of Disposition 1√2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		osition (Name of ematory or other place ew Cemeter	Masz	Date 9	20c. Location - City or Town, State West Hazelton, PA
balli permit. Departm Importa any Inju		21. Signature of Funeral Sepige Licensee	2 I	22. Name and Address DeVol Fune	s of Facility ral Home Gaithe:	, 10 Ea	st Deer Park Drive, MD 20877
Physiciar /Medica Examine			d the death. Do not en ine.	nter the mode of dying	g, such as cardiac	or respiratory a	Approximate Interval Between Onset and Death
58 / 50, ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): s a consequence of):				
tifical							
the death certific ty the attending place	Physician/M		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delivery  Month Day Year
T that	þ	Part II. Other significant conditions contributing to death	but not resulting in the t	underlying cause give	en in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 1 Unknown
The ate has page	Completed					24a. Was auto perfe 1 Yes	
VITAL I siclan: The scertificate irector, pag	Be	25. Was case referred to medical examiner?		la.	26. Place of Deat	h (Check only	one)
	2	1) Yes 2□ No			4 LI Nursing Ho		idence 6 □Other (Specify)
VISION C Attending P r death. ector: After t by the funera		27. Manner of Death		Work	/ at ⟨? Yes 2 □ No	28d. Describe	how injury occurred
DIVISION If or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of ir	njury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office			(Street and Number or Rural Route Number, wn, State)
Hospita 4 hours Funeral ely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physician; To the besis and magnets and magnets	of examination and/or i	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	and due to the	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
To the within 2.	Med	29b. Signature and title of certifier	nated.	29c, License	e number		29d. Date signed (Month, Day, Year)
7 × 5 8		1 200	na Over				mas 5 2008
6		30. Name and address of person who completed cause of	death (Item 23a) /Tyree	Print) DIO	1 mes	110	Pork Di
		IRR N BRECKER	mo one	5,11	Pryp	X con	mo 20902
Regis	State		trar's Signature	hads)	, ,		

DHMH 17 Rev 1/2001

Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Richard J. Heiman 2008 2:10 May 8, Α /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Director 76 June 19, 1931 Kansas 349**-**24-4752 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Chevy\_Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 USA 6704 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ty Yes 2 No If Yes, Give 1956-59 Year or Dates: 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Practice Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Joseph Heiman Aubrey Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Maple Avenue Chevy Chase, MD 20815 Marilyn Heiman/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State 05/09/08 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month 4□Pregnant at time of death 9□Unknown Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Director: After Hospital or Attending 24 hours after death. 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated 29b. Signat and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D64615 May 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Genevieve Wroblewski,

MAY 0 9 2008

32. F

gistrar's Signature

31. Date filed (Month, Day, Year)

M.D. 6001 Muncaster Mill Road Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William may ames /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner County General Hospitar Calum 8. Date of Birth (Month, Day, Ye Mar. 11, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1<sup>Year)</sup> 1926 **Funeral** Days Country, 1**X** M 2□ F 82 220 16 6669 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d Inside City Limits 10a. State 1 ☐ Yes 2 No **Funeral Director** Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21042 United States 2901 Cypress Bay Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1944–46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Be Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Aviation Adm. Statistician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis F. P. Hines Regina Halloran 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2901 Cypress Bay Court Ellicott City, MD 21042 Mary C. Hines/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 5-13-2008 Flintstone, MD Rocky Gap Vet. Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month for Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ₹ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year, Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

(ISH) State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAY 0 9 2008

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Status & Joseph

5005

Registrar

Signal Bell lane Clarksulle MD 2102

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav 2008 Richard Charles Havel May 6. 1700 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1⊠M 2□F 85 New York Jul 14, 1922 097-16-4628 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Calvert Owings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20736 USA 6425 Casey Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify Specify: 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) College Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Havel Emily Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Owings, MD 20736 Lynn Buckley (daughter) 6425 Casey Way 20b. Place of Disposition (Name of cemetery, crematory or other place) May 9 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Lee Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Fun al Service Licensee 22. Name and Address of Facility 21. Signature Lee Funeral Home Calvert, PA J. Coff Owings, MD 20736 8125 Southern Maryland Blvd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Month Day 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1□ Yes 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is m any injury or other traum. once.

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

**Director** 

r 28a-f show notified at

ral", or items 2 Examiner mu

the Medical

Pages 1 and 2 should be filed within 72 hours after innent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten

Baltimore, Maryland 21215-0036

ö ns 23a or must be Directo

Funeral

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Completed

death with the Maryland

Examiner Physician/Medical þ Completed Be P Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed 94 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 🖺 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death

2 T Accident

3 ☐ Suicide

29a Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be

MAY

determined

1 (4 Inpatient 28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

3111

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hung Davis, MD Annapolis, MD 2001 Medical Parkway

31. Date filed (Month, Day, Year) State Registrar

Medical

32. Registran's Signature

2008

within 24 hours a To the Funeral I

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician;

Medical To the 29b. Signature and title of certi ppleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 40 Year) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar MAY 0 8 2008

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

amend line 15 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 05/07/08 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2008 **Physician** 5:35 A M James L. Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 5226 B Sands Road Lothian If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. U.L.y 23 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1953 **Funeral** 1**X** M 2□ F Maryland 54 Yrs. 214-66-0839 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be mutilled at 1 ☐ Yes 2 No Lothian Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20711 USA 5226 B Sands Road death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Specify: ð Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Auxilliary Prince George's Co. and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) 9th College (1-4or 5+) Board of Education Building Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be James A. Johnson Mary E. Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau once. 15411 Peerless Ave Upper Marlboro, Md.20772 Florence Wilson(Sister) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LOV Moses Cem 5-10-08 Drury, Md. 4 Donation 5 Other (Specify) Windows of Acid ons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 B. Keese MO6483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hepotocellular disease or condition resulting in death) /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Athors after death. Athor the tribing this certificate has been signed by the attending physician and Elemeral Director. After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) D 50653 Gyan.c. Surono. Road Deale 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 851-Deale Churchto 31. Date filed (Month, Day, Year) MAY 0 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17:25 May 2, 2008 David KAPLAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examine Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Y 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 047-07-9782 1**X**□M 2□F Months Days Hours Min. 1914 Reveré, MA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, In Modical Eventines of the notified a Rockville Director MD Montgomery 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6111 Montrose Rd., #309 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married timore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Jewelry Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be finith and Mental h Be Sarah (Unknown) Abraham Kaplan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6111 Montrose Rd., #309 Rockville, MD 20852 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is a
any injury or other trau Roseline Kaplan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/5/2008 Fairfield, CT Ahavath Achim Cem. 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Igrchinsky, Hebrew Nungral Homen, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final terioxlesotic **Physician** Cascliovascula disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 1 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) P.O. 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate funeral director, page 2 1 No Vital 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 2, 2000 MXI Yeverny Gindsway

State Registrar town

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 0 7 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician TY 000 M 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 2858 Jessup Rd. Jessup 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 3/3/1938 West VA 1 □ M 2 🔀 F Months Hours 70 578-48-0274 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 1 ☐ Yes 2 ☐ No r 28a-f sh notified Director Anne Arundel Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or be Pages 1 and 2 should be filed within 72 hours after death with ral", or items 23a Examiner must b 20794 IISA 2858 Jessup Rd Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married "natural", or White Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be If item 27 Is marked or other traumatic ev Eva Mae Collette Charles Deboaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessup, MD 20794 2858 Jessup Rd. David Edward Link, Jr. Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important; If iter any injury or oth once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gard 5/6/2008 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was .... autopsy performed? Yes 2/K/No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

neral Director; / 24 hours a within 24

Medical

MAY 0

29b. Signature and title of certifier

31. Date filed (Month, Day,

4 Homicide

29a. Certifier

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person whi

egistrar's Signatut

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5, perFH, 5/12/08, DPS, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4, Louise Morrison 2008 12:30 p M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Brooke Grove Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 200 1919 Director 88 June 21, Georgia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 16930 Harbour Town Drive 20905 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Nexical Exprintment any injury or other traumatic event, the Nexical Exprintment any once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ★No If Yes, Give 1 □Yes 2 x No SpecifyWhite ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira Dadisman Ida Sayre ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Ross Morrison/Son 16930 Harbour Town Drive, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 9 2008 Parklawn Memorial Park 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 army 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Acute Myeloid Leukemia Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myelodysplastic Syndrome Months Examine Due to (or se a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) the 1 □Yes 2 □No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension s been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has irector, page 2 s autopsy perform 1 ☐Yes 2 🗷 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation after death.

Director: After din by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Medical

Box 68760, P.O. Division of Vital Records, To the Hospital within 24 hours a To the Funeral C completely

Baltimore, Maryland 21215-0036

XI CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number

D0057630

10301 Georgia Avenue, #209, Silver Spring, MD 20902

29d. Date signed (Month, Day, Year) May 5, 2008

State Registrar 31. Date filed (Month, Day, Year)

Anuradha Arun, MD

29b. Signature and title of certifier

MAY 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Ye ar Herndon Messegee 2008 2:42 Α May 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 23, Social Security Number 7. Age (In vrs. last birthday 1 X M 2 □ F Months Washington 1918 89 576-16-2567 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐Yes 2 No Maryland Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 9628 Trailridge Terrace 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Sea Captain 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Forsyth George Frazer Messegee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9628 Trailridge Terrace
Potomac, Maryland 20854 19a. Informant's Name/Relationship (Type. Print) Thuy Thi Messegee, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State May 13. 1 Burial 2 ACremation 3 Removal from State Fairfax Memorial Park 2008 4 ☐ Donation 5 ☐ Other (Specify) Fairfax, Virginia 22. Name and Address of Facility
Fairfax Memorial Funeral Home
9902 Braddock Road, Fairfax, 21. Signature of Funeral Service Licensee Thim Migh M01508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Ventricular Arrythmia disease or condition resulting in death) Due to (or as a consequence of): Cardiomyopathy Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Failure Due to (or as a consequence of): Acute Renal Failure 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 TYPS 2 No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🛚 No 1 □Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

/Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Certification: To

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permit. Page Department o Important: If any injury or

Maryland 21215-0036

Baltimore,

Physician The law requires that the death certificate be executed

and burial-tra physician the use as attending the þ s been signed be should be deta page 2 certificate s after dec. ral Director: After hy the funeral di this

of Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital 24 hours a

To the within 2 To the

Division

3 ☐ Suicide

4 ☐ Homicide

29b. Signature and title of

Delroy Anglin,

IF FEMALE: 23b. Was decedent pregnant

1 Tes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 7, 2008

29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

29c. License number

D55148

State Registrar

completely filled in by

31. Date filed (Month, Day, Year)
MAY 0 8 2008

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5-0 led w Hygir	10 13	ပ	17. Father's Name (First, Middle	e, Last)						Jenn				
21215-0036 and be filed within 7 Mental Hygiene.	arkec		Raymond Leo Ma  19a. Informant's Name/Relation	gnus		19b. Mailir	ng Address (Str	eet and Num	ber or R	tural Route	Number,	City or Town	, State,	Zip Code)
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Active than an Active than the Maryland Active than the Maryland State of the state of the	tant:	1	4 Donation 5 Other	Specify:	St	auffer 22.	Cremato Name and Addre	ess of Facilit	<u>С 57</u> у	19/08				
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Box 68760 e death certificate b	ding per as the	an/	23b. Was decedent pregnant in past 12 months?		ve birth regnant at time of	J M	Fetal death Other (Specify)	3E010p	nc pregn	aricy				·
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Divi alor	al Dir	Certification:		Could not be determined (Spe	ecify)						JW11, Oto			
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Division of Vital   To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Dir completely filled in	Medical	one) 2 Medical	Examiner: On the b	asis of examination	on and/or invest	tigation, in my op	inion, death	occurre	at the time	, abto a	na praco, a		<u> </u>
£ i	7 S	Me	29b. Signature and title of ce					cense numb	er		1	May 14,		Month, Day, Year)
			Dan m	Wind.	mD		C	).C.M.E.				iviay 14,	2006	
			30. Name and address of pe		cause of death (	Item 23a)	111 Penn St	oot Balti	more	MD 2420	11			
5			Donna M. Vincenti		nt Medical E		4	ect, Daill	more,	1410 2 120				
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 1105 P 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 1619 Millersville RD. Millersville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Numbe 231-07-1287 7. Age (In yrs. last birthday Funeral Country A Months Days Hours 6/4/1921<sup>ar)</sup> XXM 2□F 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits fshow r 28a-f show notified at Millersville MD Anne Arundel 1 ☐ Yes 2x No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be ι USA 21108 1619 Millersville Rd. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. TXXYes 2 No 44-66
If Yes, Give
Year or Dates: 1 Never Married 20 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2€No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOD-USN Sr. Chief marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hismt; If item 27 is marked oth Lizzie Belle Holland Altah Maurice Nichols, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 1619 Millersville Rd. Millersville, MD 21108 Florence Nichols Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any Injury or ol Burial 2 Cremation 3 Removal from State Millersville, MD Baldwin Memorial Cem 5/9/2008 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Pureral Service Linesee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Eper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final bladder Physician LUNCES MAM. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CMLO ENJOCUIVO くしょう Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed Exami that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 14 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Varifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa 0 (5272

State

31. Date filed (Month, Day, Year) Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2008 MAY 0

32. Resistrar's Signature

Suite 300 Amp. 115 MO 2140

Certificate of Death

Reg. No.

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year  $\boldsymbol{A}^{\mathsf{M}}$ 2008 MAY 9:33 GEORGE OLSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CENTREVILLE QUEEN ANNE'S HOSPICE OF QUEEN ANNE'S HOSPICE CENTER 8. Date of Birth (Month, Day, Year)

APRIL 2, 1923

9. Birthplace (State or Fore Country)

NEW HAMPSHIRE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 **X**M 2 □ F 85 003-10-9439 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No ANNE ARUNDEL MARYLAND ANNAPOLIS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 438 FERRY POINT ROAD 21403 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1943—1946 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER AND OPERATOR INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ERICK GODFRIED OLSON OLGA JOHANSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY D. OLSON/WIFE 438 FERRY POINT ROAD, ANNAPOLIS, MARYLAND 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State **MAY 10** 1 ★Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KENNEDYVILLE, MARYLAND SHREWSBURY CEMETERY 2008 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. mal 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AMYOTROPHIC LATERAL SCLEROSIS Due to (or as a consequence of) Sequentially list conditions, land the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of certificate be executed Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? certificate 2 ☐ No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOUSE Hospital: 1 ☐ Yes 2[**X** No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. he Funeral Director: After t Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061776 MAY 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 116 DEFENSE HIGHWAY, SUITE 400, ANNAPOLIS, MARYLAND 21401 BRIAN WOLF, M.D. 31. Date filed (Month, Day, Year) State MAY 0 9 2008 Registrar

DHMH 17 Rev 1/2001

P.0.

Records,

Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Guadalupe **Physician** Maria Pacheco Month 7,2008 May 10:15a <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7501 Democracy Blvd. #B317 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 XF 53 Director none Sept.8,1954 Mexico Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Montgomery Bethesda Director 1 Tyes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7501 Democracy Blvd. #B317 20817 Mexico Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or Specify: Mexican 1X Yes 2□ No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Pedro Pacheco Paula Rodriguez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health at Important: If Item 27 is any injury or other trau Ruben Barrera/Husband 7501 Democracy Blvd. #B317 Bethesda, Md20817 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jardine De Los
Angeles 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State Nuevo Laredo, Mexico 5 Other (Specif 5/12/2008 uneral Service L 21. Signat ve 22. Name and Address of Facility PHILIP D RINA 924T Columbia LBIve.Silver Service; Ma. 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ETASTATIC HEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examine death certificate be executed and Due to (or as a consequence of): burialphysician Physician/Medical the as attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Jas autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 🖪 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician:

n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu To the Hosp within 24 hou To the Fune completely fil

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tine of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D29675

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralph V.Boccia M.D. 6420 Rockledge Drive Suite 4100 Bethesda, Md20817

May8,2008

State Registrar

Medical

31. Date filed (Month, Day, Year)

MAY 08 2008

29a. Certifier

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician  $A^{M}$ William Ellsworth Reid May 2008 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Suburban Hospital</u> Bethesda Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** Days Hours 1**½** M 2 □ F **Director** 100 577-56**-**3264 25, 1907 Nortolk, Oct. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo N/A DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20009 1617 V St., N.W. U.S. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 Specify: Black 3 ☐ Widowed 4 🙀 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry any Injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government 5+ Asst. Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ဂ္ William Reid Margaret 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Reid, Jr. / Son 3298 Chestnut St., N.W. Washington, D.C. 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/8/2008 Lincoln Cemetery Brentwood, MD 22. Name and Address of Facility McGuire Funeral Service, 21. Signature of Fluneral Service Licensee indre hompson 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Week Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be exe Due to (or as a consequence of). Box 68760. Physician/Medical attending | for use as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performe certificate 1□ Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1點 Inpatient 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို After this c 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔽 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

م Records, Ш **Division or Vital** 

MAY

To the Funeral Director: completely filled in by the within 24 ? To the Fu

> State Registrar

29b. Signature and title of certifier

A. Rajvanshi, M.D. 31. Date filed (Month, Day, Year) 32 egistrar's Signature MAY 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D37891

29d. Date signed (Month, Day, Year)

May 2, 2008

		State of Maryland / Dep 1 - For amend #17 Per INF G879 5/30/08	artment of Health an	d Mental Hygie	ne .No. 0 0 0 0 1 C 3 3 3
Physi		1. Decedent's Name (First, Middle, Last) Eric Reisfeld		2. Date of Death Month April 27	Day Year 3 Time of Death
/Med Exam		4a. Facility Name (If not institution, give street and number)  9905 Lorain Avenue	4b. City, Town, or Location of E	leath	4c. County of Death  Montgomery
Funera Directo		5. Social Security Number  082-16-4940  6. Sex 1 X M 2 F  7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24		
Maryland -f show lied at	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgomery  Silver S		5072.0-	10d. Inside City Limits 1  ☐ Yes 2 ☒ No
th with the 23a or 28a st be notii	al Director		10f. Zip Code 20901	-	Citizen of What Country?
IOTCE, INIGIT/IBING ZIZID-UU3D ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F  1 ☐ Yes 2√√2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
ithin 72 hours af ithin 72 hours af ne. ne. Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	working	b. Kind of Business/Industry
filed w Hygier Sther #			inessman 18. Mother's	Name (First, Middle, Mai	Real Estate iden Surname)
Aaryland Z 2 should be filed w n and Mental Hygie 1 s marked other t raumatic event, th	To Be		-Unkno	wn Bertha Z	erstandig
Mary d 2 sho th and th and 7 is ma trauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address <i>(Street and Number o</i> 05 Lorain Avenue		
ages 1 and and of Health t: If item 27 y or other tr		20a. Method of Disposition  1 Burial 2 Stremation 3 Removal from State	osition (Name of ematory or other place)	Date 200	c. Location - City or Town, State
permit. Pages 1 Department of H Important: If ite any injury or ot	<u> </u>	21. Signature of Fune al Service dicenses	coln Crematory <sup>112</sup> 2. Name and Address of Facility 1040 Rockville F	Simple Trib	
Physiciar	1	23a. Part 1. Enter the disease, or complications that cause d the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Pneumonia			The state of the s
/Medica Examine		Due to (or as a consequence of):			
outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of light) that initiated events (C.			
cate be executed physician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):			
death certiff death certiff e attending of for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  □ Yes 2 □ No  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
that the detache	٥	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobac	cco use contribute to the cause of death?
v requires that the been signed by the should be detached	ed by	Consession Heavy F 11		1 □ Yes	2 No 3 Probably Multiple
The law resate has been page 2 sho	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  ↑No 1 □ Yes 2 □ No
Sician: certificat rector, p	Be	25. Was case referred to medical examiner?	Other	Death (Check only one)	
ng Phy ter this	n: To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death	III 3 DOA   4 Nursi	ng Home 5 TResidence 28d. Describe how	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to map in the funeral director, page 2	Certification:	2 Accident survestigation 3 Suicide 6 Could not be determined determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
le Hospital 124 hours le Funeral	Medical C	29a. Certifier  1 X Certifying Physician: To the best of my knowledge, dea  (Check only one)  1 Medical Examiner: On the basis of examination and/or i and manner stated.			
to within to the sound to the s	Me	29b. Signature and title of certifier  Kabert H Lucus MD	29c. License number MD D0055522		Date signed (Month, Day, Year) pril 29, 2008
1		30. Name and address of person who completed cause of death (Item 23a) (Type	·	O	20010
	tate	Robert H. Gerard, MD 1500 Forest Gle		spring, MD 2	20910
- Regis	strar	MAY 0 8 2008 Steer B. Apr	W)		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month EANOR 2110 Physician ODGERS 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crownsville 1278 Roberts Rd. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Min. 1 □ M 2 KF Days Hours 7/5/1919 PA 88 Director 178-14-3778 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes ⊋₩No Crownsville **Funeral Director** MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21032 1278 Roberts Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White Specify: Baltimore, Maryland 21215-0036 Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PG County Schools Teachers Aide 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Smith Samuel Hoover 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crownsville, MD 21032 Daughter 1278 Roberts Rd. Jenny White 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/5/2008 Cedar Hill Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Septine Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lings Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Day Month requires that the death in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. n signed by the a ld be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 2□ No 1 ☐ Yes certificate Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes 2 No 1 🔲 Inpatient ို this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No al or Attendi s after death. 2 Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours a Hospital 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier W YENSE HEHWAY ANAPOL d cause of death (Item 23a) ame and address of person who com

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 7 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** SANCHEZ 01:30A EZPERANZA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY KOCKVILLE, MARYLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

MARYland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours 1 □ M 2 F NONE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 Des 2 □ No GAITHERS BURG, MARY LAND Director MONTGOMERY 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20878 KOAD #12 CLOPPER Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2□ No If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be DANCHEZ VILLEGAS VITIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CLOPPER ROAD #2, GAITHERSBURG, MO 702 DIAZINOTHER LEGAS 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 06/16/2008 HALL RIVER, NC 3 Removal from State STERI CYCLE 22 Name and Address of Facility 21. Signature of Fun I Service Lizens SGAH, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Extreme prematurity Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 2 No 3 Probably 4 Unknown Hyperkalemia, Hyporalcomia, Hypernatromia Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Respiratory distress syndrome, Hypotensia 230/7 weeks gestation 2 No Hyper succession Hyper 1□ Yes certificate Physician: 26. Place of Death (Check only one) 25. Was case examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner: 1 ☐ Yes 2 🔀 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Japital c.
4 hours after dec.
-aral Director: A'
in by the 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide To true.
within 24 hours a.v..
To the Funeral Direct
'~tely filled in by 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier May 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Iafolla, mo

32. Registrar's Signature

9901 Medical Center Drive Rockville, Maryland 20850

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		For						artmen	t of H	ealth a	nd Me	ental Hy	giene			
		= State Registrar AMEND#23	a(c)pe	erMD5/7/0	08,BM	W,McC	Ce	rtificat	e of L	Death			Reg. No.	2008	)	16781
Dhyniai		1. Decedent's Name (First, M										2. Date of De	ath Day	Year	3.	Time of Death
Physici /Medic		John Kenneth	Sta	na							]	May 4,				8:50am <sup>M</sup>
Examin	er	4a. Facility Name (If not institu						4b. City,	Town, or	Location o	f Death		4c.	County of Dea	ith	
	14	18700 Walkers 5. Social Security Number	6. Se				st birthday)			ry Vi		9 Date of Dir	th	ntgome		(State on Familia)
Funeral Director		204-30-4137			7. Age	66	Yrs.	Months	Days	Hours	Min.	(Month, Da	ıy, Year)	C	ountry)	(State or Foreign
the second second		Usual Residence of Decedent			L							iug 2,	1741		IA	
nylan how	_	10a. State 10b. Cou	nty			10c. City,	Town or Lo	ocation								side City Limits
e Ma 8a-f s	Director		tgome	ery		Mon	tgome	ry Vi		ge						☐Yes 2∏No
with the a or 2 be no	Dire	10e. Street and Number	01		1 11	010		10f. Zip						zen of What C		
72 hours after death with the Maryland 72 hours after death with the Maryland Inatural', or Items 23a or 28a-f show dical Examiner must be notified at	eral	18700 Walkers	Cho	12. Was Dec			13		1886	ienanio Orio	sin? (Snec	oify Yes or No		ited St		
fter de	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2</li></ol>	Married	Armed F 1 ☐ Yes	orces?			If Yes, spe	cify Cuba	ın, Mexican	, Puerto F	lican, etc.)	,-	Black, Whi		arari,
urs at al'; o	by	3 ☐ Widowed 4 🎇 Divor		If Yes, G Year or I	ive -			1 ☐ Yes	2XNo	Specify:				Specify: Wh	ite	
72 ho natur	Completed	15. Dece (Specify only hi	dent's Edi	ucation	)		16a. Dece	dent's Usua	al Occupa	ation	of workin	a	16b. Kir	nd of Business	/Industry	
ithin ithin and "nan "	nple	Elementary/Secondary (0-1		College (		+)		kind of wo DO NOT us			Or Working					
led w lygier her th	S	17. Father's Name (First, Mid	dla Laat)				Vice-	Presi	dent		r'a Nama			il Mana	igeme	ent
ntal F ed ot	Be	John Francis	. ,	19							rs Name 7 Kra	(First, Middle nazak	, Maiden i	Surname)		
thould the Me	2	19a. Informant's Name/Relati					19b Mailir	na Address	(Street a				er City or	Town, State,	Zin Code	a)
nd 2 s Ilth ar 27 is r trau		Sharon Ward		Daugh	nter			-						, FL. 3		•
s 1 al f Hea item othe		20a. Method of Disposition						osition (Nar matory or c	-		ay 9,	ate		cation - City or		
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Diopartment of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe			State	I .		Cemet		1	ay 9, 008	•	Pitt	sburgh	, PA	
partin porta y inju		21. Signature of Funeral Serv	rice Licens		1					s of Facility	DeV	ol Fun	eral	Home		
88268		Youth	-A	Worl			- 1							urg, MI	. 20	0877
		23 . Part1. Pinter the disease shock, or heart failure.	, or comp List only o										rrest,		Appi	roximate rval Between
Physician		Immediate Cause (Final disease or condition	142	a. N	ON	isci	hen	1 lac	6	-rel	ic my	rep-1	hy		y Y	et and Death
/Medical Examiner		resulting in death)		Due to	(or as a	conseque	nce of):	(1)								
	-K	Sequentially list conditions,		b. Due to	Jor As a	conseque	nce of):	110							7	ews
uted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	7	00	acc	0	, 10	_/_	Ca	Pi)				4	1005
execuin and ial-trai	Еха	resulting in death) Last		Due to	(or as a	conseque	nce of):								/	
cate be executed physician and the burial-transit	dical			d												
	Med	IF FEMALE:														
leath certific attending p	lan/l	23b. Was decedent pregnant in the past 12 months?			birth 2	2 □ Fetal d	leath 3	⊒Ectopic pr					2	3d. Date of de	livery Day	Year
ne dea the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Preg 9□Unkr		time of dea	ıth 5□	Other (sp	ecify)					WOTH	Day	i cai
The law requires that the death certifiate has been signed by the attending loage 2 should be detached for use as		Part II. Other significant con	ditions co	ontributing to o	death but	t not resulti	ing in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco us	se contribute t	o the cau	use of death?
ne law requires the has been signed ge 2 should be de	d by								ŭ			1 🗆	Yes 2	]No 3∏F	robably	4 <b>X</b> Unknown
w req beer shou	lete											24a. Was	an	24h Were a	utonsv fi	ndings available
The la cate has page 2	Completed											auto perf	psy ormed?	prior to death?	completi	ion of cause of
	Be Co	25. Was case referred to med	lical							26 Place	of Death	1 Yes (Check only	2 <b>X</b> No	1 Ll Ye:	3 2□	No
ryslci is cer direc	0	examiner? 1 ☑ Yes 2 ☐ No		Hospital: 1 🗆	Inpatien	nt 2 EF	R/Outpatier	nt 3 DC	A Othe	or.				Other (Spe	ecify)	
Attending Physician; r death. ector: After this certifice by the funeral director,	n: T	27. Manner of Death 1☑ Natural 5 ☐ Per	odina	28a. Date	of Injury		8b. Time o	of 2	8c. Injury Work			8d. Describe				
eath. or: Al	atio	2 ☐ Accident inv	estigation				,	М		Yes 2□N	40					
or Att ter de Virect n by t	Certification:		uld not be ermined	20e. Flac	e of injur ding, etc.	ry - At hom . <i>(Specify)</i>	e, farm, str	reet, factory	, office		2	Bf. Location ( City or To	Street and wn, State)	d Number or F	ural Rou	ite Number,
pital ours al		29a. Certifier 1 ☑ Certi	fulna Dh	releism. To th	o hoot o	f my knowl	odeo dost	h cooured	at the tim	no data an	d alass a			and manner a	4-4- 1	
To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medi	cal Exam	iner: On the I	basis of one	examinatio	on and/or in	vestigation	, in my o	pinion, dea	th occurre	d at the time	, date and	place, and du	e to the	cause(s)
Vithin Fo the Somple	Me	29b. Signature and tille of cer	tifier	1.		1.	>	290	. License	e number	9-	30-08	29d. Date	e signed (Mon	th, Day,	Year)
		)/ /	~ /	Cana	u. K	X		T	00	384	135		1	lay 5	7	Pocifi
O		30. Name and address of per-	son who c	ompleted cau	ise of de	ath (Ite)n 2	3a) (Type,	Print)	Aa	ron E	. Ke	nigsbe	rg	-/-	, _	20cf 0902
		10313 GE				ENUE	= #	F 30	0	SIL	-VER	5P	RINE	1 MD	20	0902
Sta		31. Date filed (Month, Day, You			Registra	r's Signatu	re	. 66 -								
Registr	ar	MAY 0	ZUU		SHOW	13.	C-23	as s								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Voor **Physician** 10:20 pM Yun-Kyu Song May 04 2008 º/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Collingswood Nursing Center Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1**区**M 2□F Director Korea 212-80-6461 March 15, 1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts Director 1 TYes 2 □ No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 299 Hurley Avenue 20850 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 x Married 1 ☐ Yes 2 ☒ No Specify Specify 3 ☐ Widowed 4 ☐ Divorced Asian Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jaekwan Kim Chang-Kun Song ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 154 Gibbs Street, #211, Rockville, Maryland 20850 Wooza Chung - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【■ Cremation 3 ☐ Removal from State 05/07/2008 Brentwood, Maryland 4 □ Denation 5 □ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Servic - Ligensee Jar 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fina Physician 2 years disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 KUnknown Hypertension 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy perform certificate 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 🗷 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient this After thi funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 X Natural 5 ☐ Pending investigation after death.

I Director A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28656 May 6, 2008 30. Name and address person who completed cause of death (Item 23a) (Type, Print) #208, Rockville, Maryland 20850 Ravi Passi, M.D., 15225 Shady Grove Road, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 07 2008 Registrar

			. For	State of Maryla	nd / Depa	artmer	nt of Health and			_	16783
			1 - State Registrar		Ce	rtifica	e of Death		Reg. No	-000	10100
	Physici /Medic		1. Decedent's Name (First, Middle, Las	rroth S	led	9e		2. Date Mor		2008	3. Time of Death
	Examin		4a. Facility Name (If not institution, give	street and number)	-	4b. City	Town, or Location of De		4c	County of Death	h
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	Funeral		Social Security Number     6. Security Number	C 14 00 C	. last birthday)	If Unde Months	r 1 Year   If Under 24 H	fin. 8. Date	e of Birth nth, Day, Year)	9. Birth	nplace (State or Hereign untry) nnsylvania
	Director		379-30-1242	LM 26 P 80	Yrs.	]		Dec	15, 1	1927 Pe	nnsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Aaryl I eho	5		ontgomery	g.	1,,,,,,	Spring				1 ☐ Yes 2 HNo
	286-	ec l	Maryland Me  10e. Street and Number	Jiregomery		-	Code		10g. Ci	tizen of What Co	untry?
	Mith Ba or	<u> </u>	12208 Livingst	on Street			0902		USZ	A	
	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23a or 28e-f ehow ta Medical Examinar must be mailfied at	Funeral Director	11. Marital Status	12. Was Decedent Ever in t	U.S. 13.	Was Dece	dent of Hispanic Origin? cify Cuban, Mexican, Pu	(Specify Ye	s or No-	14. Race - Ame	
9	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XXI				Jeno Hican, e	etc.)	Black, White	e, etc.
8	rel', o	ρ	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 U Tes	218 No Specify:			Specify: W	hite
5	natu Ical	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(Give	kind of w	al Occupation ork done during most of	working	16b. K	ind of Business/	Industry
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DIE.	be fi	Be	17. Father's Name (First, Middle, Last) Oliver Carruth				Sally W		MIGGIO, MIGIGOI	i Sumame)	
3	should bind Ment marked umatic e	٦		Firm a Orient	10h Maili	na Addros	s (Street and Number or		Alumbor Cibe	or Tourn State 7	Zin Code)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 ie marked other than "naturel", or Iteme 23a or 28e-1 show other treumatic event, II a Medical Examinar must be notified at		19a. Informant's Name/Relationship (7								
	1 and Healt em 2 ther		Gale Shannon/D		Place of Dispo		iffith Road	Date Date		ocation City or	
چ	nt of		1 ☐ Burial 2 € remation 3 ☐	Removal from State	cemetery, cre	matory or		May 6	5		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 id eny injury or other tre		4 ☐ Donation 5 ☐ Other (Specify 21. Sign hure : Funeral Species Lich	1	-			2008			ia, Virginia
Ba	Department Department of the partment of the p		21. Signal of Police 2 September 21.	Cons	-	Fran	nd Address of Facility CIS J. Colli	ns Fur	neral He	ome Inc.	ng, MD 20901
			23a. Fart1. Enter the disease, or comp	nlications that caused the de						ver spri	Approximate
			shock, or heart failure. List only	one cause on each line.		-	as or aying, such as said		2101, 211001,		Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	a HSC	-11						DWIE-
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68	death certificate b ettending physi d for use as the b										
Вох	death certifica e ettending phi d for use as th	<u>₹</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		Je				23d. Date of del	ivery
	death e ette d for	Cia	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		⊒Ectopic p ⊒Other (s				Month	Day Year
P.O.	t the by the ache	hys	9 Unknown	9□ Unknown		_					
	w requires that the de i been signed by the should be detached	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying	cause given in Part I.	23	e. Did tobacco	use contribute to	the cause of death?
ğ	quire on sig	ed th						_	1 ☐ Yes 2	□No 3□Pr	obably 4 Unknown
ပ္သ	s bec	piet						24	a. Was an	24b. Were au	utopsy findings available completion of cause of
æ	The law cete has b page 2 sl	Completed						10	autopsy performed? Yes 2/2/N	death?	2 □ No
ita		0	25. Was case referred to medical				26. Place of			, , , , , , , ,	
<b>&gt;</b>		ToB	examiner?	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatie	nt 3 D	OA Other: 4 Nursin	ng Home 5	Residence	6 ☐Other (Spe	cify)
0	ng Ph ter th neral		27. Manner of Death 1(△) Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of	28c. Injury at Work?	28d. De	scribe how inju	iry occurred	
<u>ō</u>	ath. ar: Af	atic	2 Accident investigation	1		М	1 ☐ Yes 2 ☐ No				
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		treet, facto	ry, office		cation (Street a y or Town, Stat		ural Route Number,
	rs eff	Cer									
	To the Hospitel or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral director.	edicai		ysician: To the best of my kr niner: On the basis of examin							
	To the within 24	Med	(and)	and manner staffed.		1 00	- Lissana aumbas		104 0	ata signed (Mont	th Day Your
<b>\</b>	5 ½ 5 g		29b. Signature and title of certifier				bc. License number	8		ate signed (Mont	
7	(		And)		m Dra	t	100042	0	0 1	ay 5, .	
	)		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type	, Print)	2101 mes	hocal	ran	Dr.	60)
			31. Date filed (Month, Day, Year)	32 Registrar's Sign			NALZ	Dri	er m	0 20	702
	Sta Registi			108 Jane	b. 60	Belle )	,	J -			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 01, 12:20 am 2008 Harold Sakkestad May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 X M 2 □ F Director 115-03-1486 88 21, 1919 New York Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 □Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 601 Suffield Drive 20878 United States within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XX Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Telephone permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If them 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Sakkestad Anna Stange 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sakkestad/ Daughter 601 Suffield Drive, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/12/2008 4 Donation 5 Dother (Specify) Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. En / r the dis-late, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in tail it. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by divertulosis recent 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1 Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 □ DOA Certification: To 1 Inpatient After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No after death within 24 hours after dea To the Funeral Director completely filled in by th 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 29b. Signature and title of contifi

31. Date filed (Month, Day, Year)

Q

MAY 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IFFMAN

. Registrar's Signature

DHMH 17 Rev 1/2001

0 10+1 29c. License number

MEDILAL CTR

			For State Of Mary Registrar		rtificate of Death	Reg. No	2000 15 185
Start Start	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	M
	/Medic	al	Dorothy Elizabeth Spector  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	May 7, 200	08   1:40 A'''
-4	Examin		Sunrise Assisted Living		Frederick	F	rederick
<u> </u>	Funeral		5. Social Security Number 6. Sex 7. Age (II	yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
j.	Director		212-22-6657 Usual Residence of Decedent	80 TIS.		Sept. 1, 1	927 Maryland
	yland now at			c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar a-f sh tified	ctor	Florida Broward T	amarac			1 ☐Yes 2X No
	ith th	Directo	10e. Street and Number		10f. Zip Code		itizen of What Country?
	eath v	Funeral	9551 Weldon Circle  11. Marital Status 12. Was Decedent Eve	r in U.S. 13. V	33321 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	USA pecify Yes or No-	14. Race - American Indian,
0	ifter de r Item siner i	Fun	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No			o Rićan, etc.)	Black, White, etc.
5-0036	be filed within 72 hours after death with the Maryland to Hygiene.  Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 X No Specify:		Specify: White
5	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b. I	Kind of Business/Industry
121	filed within Hygiene. ther than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)	Homema	,	Own	n Home
פַ	e filed al Hygi other vent, ti	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maide	n Surname)
Maryland 21	should be filed nd Mental Hygi marked other umatic event, t	To E	Maurice Finn		Victoria		
Mar	12 sho		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Number or Ru		
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Barbara Day-Bartgis, daughter 20a Method of Disposition		Hillcrest Drive, sition (Name of matory or other place)		Mary1and 21703 Location - City or Town, State
Itimore,	0 0		1 Ma Burial 2 Li Cremation 3 Li Removal from State		1	/2008 Mou	nt Airy, Maryland
alti	permit. Page Department Important; If any injury o		21. Signature of Funeral Service Licenses				illiams Funeral Home
<u>m</u>	S E E		Kyan M. Deiger		6401 Ridge Road,		
S			23a. Part Enter the disease, or complications that caused the shock of heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	TAGE	OVARIAN CA	NCER	yr_
	Examiner		. Kensal	INSU.	Hiciency		LAR
5	三面	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	onsequence of):	71		
	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Did to (or as a 6	pidemi	ca		yes.
60,	ficate be executed physician and is the burial-transit		In ON	Wia			
68760,	ficate physis the	edical	d. Whore				
Box (	law requires that the death certil as been signed by the attending 2 should be detached for use a	m/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2		□Ectopic pregnancy		23d. Date of delivery
	ed for	Physician/M	In the past 12 months?  1 ☐ Yes 2 ☑ No  4 ☐ Pregnant at tin		Other (specify)		Month Day Year
P.O.	nat the d by the letach	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but r	not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
	signe d be d	d by	Tartin Other signment sorialions contributing to document				2 No 3 Probably 4 Unknown
COL	w requir been si should	letec				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
or Vital Records,	The lay	Completed				autopsy performed? 1 Yes 2	?   death?
ita		BeC	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	
<u>&gt;</u>	Attending Physician: r death, ector; After this certification; by the funeral director, I	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier		Home 5 ☐ Residence	1 1 37 1 13 (7
n	ding Phy h, After thi funeral	ion:	27. Manner of Death  1 Natural  2 Accident  28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe now in	jury occurred
Division	Attender death	fical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury	- At home, farm, st		28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
<u>i</u>	s after al Dire	Certification:	4 Homicide determined building, etc.	<i>Эреспу)</i>		City of Town, Ste	110)
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of e	xamination and/or ir	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the I within 24	Medical	29b. Signature and title of certifier	a.	29c. License number	29d. [	Date signed (Month, Day, Year)
	F ≥ F ö		Vallon Keiller	MD	0547	49 M	AU 7 2008
	10		30. Name and address of person who completed cause of gea	th (Item 23a) (Type,	(Pan) 200 1 0 1)	1 Inn	DERICK, Md
-	10		AHEN KEILLY, MD 80	017011	Fouse Ave, D	TIKEL	ICKICIC, ING
	Sta	ate	31. Date filed (Month, Day, Year) 32. Register	s Signature	Goode		

08-03392	
Michael Thompson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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2 -	1		-	40	å

03392	State of Maryland / Department of Health and Mental Hygiene			
hael Thompso		- For State Criticate of Death		2000 D100
Dhypinia	_	degistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Physicia edical Examin		Michael Thompson Sr	Month May 3, 200	8 7 17 15 1115
A		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Death Anne Arundel
		Rear of 74 Pleasant Street Annapolis	In Date of Block	(MM/DD/YYYY) 9. Birthplace (State or
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24  Months Days Hours	Min.	Foreign
Director		218-96-3778   X M 2 F   31 Yrs.	Jan 2	1 1977 CountMaryland
>		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
w an	- 1	Maryland Anne Arundel Annapolis		1 X Yes 2 No
yland -f she		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
e Mar or 28;	Ø.	458 Captains Circle Apt C 21401		USA
vith th		11 May Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin?	( Specify Yes or No-	14. Race - American Indian, Black, White, etc.
item:	uneral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Pu	jerto Rican, etc.)	
ufter d	ŭΙ	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 A No specify:		Specify: Black  16b. Kind of Business/Industry
ours a	훘	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		United States
11215-0036 Idee filed within 72 hours after death with the Maryland Aental Hygiene. marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 10th O Pit Crew Worker		Naval Academy
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica	통	10011	Name (First, Middle, M	Maiden Surname)
al Hy	BeC	Henry H. Thompson Jr.   Sandra Savoy		
212 ould b	흔	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Ga'Juanah H. Thompson(Wife) 458 Captains Ci	rcie Apt	20c. Location - City or Town, State
Fe, 1 and Fitten	-1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Removal from State)  20b. Place of Disposition (Name of cemetery, Removal from State)		
Pages rent of		4 Donation 5 Other Specify:	5-9-08	Annapolis, Md.
Baltimore, permit. Pages 1 an Department of Hea Important: If iter		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  821 West St.	Annapoli	s, Md. 21401
Yarry 13, West Placifies the gaused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or he				
Physician lical	failure. List only one cause on each line.			Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):		
	Sequentially list conditions.			
	iner	if any, leading to immediate Due to (or as a consequence of):		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
OX 68760, sath certificate be executed attending physician and for use as the burial - transit	ical E	d		
), be exe sician urial -	ğ	UNPENDED AMENDED		23d. Date of delivery
376 ficate g phys s the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	pregnancy	Month Day Year
K 68		past 12 months?  4 Pregnant at time of death 5 Other (Specify)		N. S
BO) e death the att	hys	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	23e. Did t	tobacco use contribute to the cause of death?
rds, P.O. B requires that the d been signed by the	by P		1Ye	es 2 🗹 No 3 🗌 Probably 4 🗍 Unknown
S, F quires en sign ald be			24a. Was	
2 2 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				ormed? death?
tal Recol	S	an Di - C Death //	1 Yes	Z NO Tes Z NO
Sion of Vital Rec Attending Physician: The I r death. ector: After this certificate by the funeral director, page	8	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	Nursing Home 5	Residence 6 🗸 Other: Scene
of Vi ing Physi After this	유	1 V Yes 2 No  27 Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?	28d. Describe Subject sh	how injury occurred
on Conding	흲	1 Natural 5 Pending FOUND: 1 Yes 2	No j	
IVISION or Attendafter death Director:	ig	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town	(Street and Number or Rural Route Number, City State)
Dival o	Certification:	4 V Homicide determined (Specify) Multi-Family Apt. Rear of 74 Pleasant Street, Annapolis, MD		
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)		
To the within To the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, dearnoon and manner stated.  29c. License number		29d. Date signed (Month, Day, Year)
- 6	1	29b. Signature and title of certifier  29c. License number  O.C.M.E.		May 4, 2008
30. Name and address of person who completed cause of death (Item 23a)				
-04	20. Name and address of person who completed cause of death (item 20a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	State	31 Date filed (Month, Day Year) 32. Engistrar's Signature		
Regi				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 8, 2008 **Physician** Harvey Eugene Wood 8:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Calvert 351 Driftwood Lane 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours 1**X** M 2□ F 92 220-01-4558 Yrs October 22, 1915 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County 1 ☐ Yes 2\No Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 351 Driftwood Lane 20688 United States "natural", or items 23a by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ages 1 and 2 should be fill out of Health and Mental H tt: If item 27 is marked otty or other traumatic even Harry Wood Catherine McKay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Wood / Wife 351 Driftwood Lane, Solomons, MD 20688 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or May 9, 2008 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORONAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, nding physiciar Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 Yes 2 No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ROK 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 performed death? 1 ☐ Yes 2□ No 2 1 NO 25. Was case referred dedical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner death 28b Time of 28a. Date of Injury 28d. Describe how injury occurred After (Month, Day Year) 1 V atural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

م or Vital Records, Division To the Hospital or Attending

1RIV

State Registrar (Check only one)

29b. Signature and title of certifier

Anwar T. Munshi, MD 110 Hospital Rd., Suite 303, Prince Frederick, MD 20678

and manner stated

Allender 30. Name and address of person who completed cause of hath (Item 231 (Type, Print)

Physici-

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month) Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Betty Jane Atkins 2008 May 2ปี 23:38 P. M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford County Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min. 216-36-6824 68 Dec. 19, 1939 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford County Forest Hill 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1213 Teaford Road 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 X No 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 8 N/A C.C.B.C. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer James Higgs Margaret E. Good 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Atkins (Husband) 1213 Teaford Road, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland May 25, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air John 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) notes is sees 2 id Electro mosegnetic 30 min Due to (or as a consequence of): Discosse COLD JORGA corpen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mellitus Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical **Examiner** MSOOU39377 Records, P.O. Box 68760, Vital the Hospital or Attending Physician: hin 24 hours after death. within 24 hours a To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification:

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

MAY 23

**Funeral** 

Director

ortant: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show Injury or other traumatic e ent, <u>the Medical Examiner must be notifiled at</u>

Maryland 212

Baltimorė,

3

Pages 1

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State Registrar

Raguraj, M.D. 502 South Atward Rd., Suite 106 Bel Air, MD 21014
2008

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rageroi. mo

Sinnarajah 31. Date filed (Month, Day, Year)

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month Theresa Ann Ayers 21, May 10:55 P.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours Year) 1 □ M 2 🖾 F Months 217-60-3815 **Director** 54 12/18/ 1953Balt., Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County or 28a-f show 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho Maryland Baltimore Baltimore Director MCYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1302 Anglesea Street Apt. T1 21224 Funeral America 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1√□Yes 2□No
If Yes, Give
Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Repair Technican n and Mental Hygie 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ew Thomas Carlon Ayers, Sr. Nellie Mae Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,21224$ Ms. Erica N. Ayers/ daughter 1302 Anglesea Street Apt. T1 Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVallS Fulleral 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Forest Hill, Maryland lChapel Bel Air 21. Signature of neral Service License 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician ( VNG Cancer disease or condition resulting in death) nontres /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Wes 2 No 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? has 24a Was an autopsy performed? res 2.2000 certificate 1 □ Yes 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) this c 1 Yes 2 No 27. Manner of eath Hospital: Other: 4 \sum Nursing Home ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) Certification: After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death

Director: , 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hour⊾ the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 24 ho

To the Fune

completely 1 (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MAI 22 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TONION HAVON I - CHARLIES MO (070l NO 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C S **Physician** 0488 DHN /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 579-38-3414 June 21 1930 Washington D.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Examples In well by notified at Director 1 ☐Yes 2 No Maryland | Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Seaborne Court 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) H.V.A.C. Hospital Unk Unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ W. Ardesser Mabel Irene Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna Rogers (Friend) 7528 B & A Blvd. Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 05/22/2008 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A 3204 Mountain Road Pasadena, Mary ONAC Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Yea 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ☐Yes 2 ☐ No the sed 9 Unknown been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen certificate has be rector, page 2 si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed Box 68760,7 P.O. P Division of Vital Records, To the Hospital 24 hours within 24 hountly to the second to the secon

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

30. Name and address of perso

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M

rho completed cause of death (Item 23a) (Type, Print)

441 DEFENSE Registrar's Signature

29c. License number

21438

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 🛛 🗎 🥄 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Bryan Charles Ashburn 01:15A<sup>M</sup> May 13, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mercy Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** Days Hours Min. Months 1 № M 2 □ F Director unknown 2 May 12, 2008 Maryland Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ▼ No Directo Maryland Anne Arundel <u>Glen Burnie</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or i USA

Race - American Indian,
Black, White, etc. 992 Drive Shoreland 21060 Funeral filed within 72 hours after death 14. Race -12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file tment of Health and Mental He tant; If Item 27 is marked oth Jury or other traumatic evem Be Timothy Ashburn Samantha Daniels မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samantha Daniels - mother Shoreland Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc | May 19,2008 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Stallings Funeral Home, P.A. <u>3111 Mountain Rd., Pasadena, </u> 23a. Part . Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** extreme prematurity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,  $\mathscr{C}_{oldsymbol{\mathcal{L}}}$ physician and the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 2√ No certificate 1∏ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Tes 2 No ပ 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46415 May 13, 2008 30. Name and address of pere of who completed cause of death (Item 23a) (Type, Print) Michael Richman 301 St. Paul Place, Baltimore, MD \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State of Ma State Registrar	aryland /		tificate of L			Reg. N	0000	16792
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of D Month	D	ay Year 1 200	
	/Medic	_	RAYMOND LEE APPELT  4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of De	MAY eath	2	c. County of De	
	Examin	er	5 LAGAN COURT			BALTIMOF	RE COUN	ΓΥ		BALTIMO	
	Funeral		1√M 2□F	e (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		in. (Month, D	ay, Yea		irthplace (State or Foreign Country)
	Director		213~30~9844	74	113.			9-29-	L933	[M	aryland
	yłand <b>now</b> at		10a. State 10b. County	10c. City, T			0 .				10d. Inside City Limits
	ie Mar Ba-f sl	Director	Maryland Baltimore		В	altimore	County				1 □Yes 2 📉 No
	with th		10e. Street and Number			10f. Zip Code	L236		10g. C	Citizen of What C	country?
	seath ns 23 must	Funeral	5 Lagan Court  11. Marital Status 12. Was Decedent 1	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba		(Specify Yes or N	0-	14. Race - Am	
ي لا	after ( or itel		1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or DatesK	No.		r Yes, specily Cuba I□ Yes 2☑ No	Specify:	ierio nicari, etc.)		Black, Wh	
A アゲドレ 15-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by		orean		lent's Usual Occup	ation		16b	Kind of Busines	
215.	in 72 n "nat	plete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5		(Give life. L	kind of work done of NOT use retired	during most of t	working		7.07.4 01 240.1100	
212 212	d with giene er tha	Completed	11 yrs. N/A	T)	Car	penter					y of Md.
	be filed ital Hygi id other event, tl	Be	17. Father's Name (First, Middle, Last)					Name (First, Middi		en Surname)	
(ひ <i>に</i> É Maryland	should I	P.	Joseph Appelt  19a. Informant's Name/Relationship (Type. Print)		19h Mailin	g Address (Street		an Ashley Bural Boute Num	<u>'</u>	or Town, State	Zip Code)
	and 2 sealth an n 27 Is i		Shirley M. Appelt (Wife)			an Court					
O. Sre,	es 1 a of He		20a. Method of Disposition  XIX Burial 2 □ Cremation 3 □ Removal from State	20h Plac	e of Dispo	sition (Name of natory or other place	i	Date		Location - City of	or Town, State
ζĤγ <i>ϻοι</i> ϤΦ Baltimore, Ma	Page ment tant: It jury o		4 ☐ Donation 5 ☐ Other (Specify)	Dular		alley M.		24~2008		ltimore	·
内内 mo la Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department or Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. argnature of Funeral Service Licensee		<sup>22</sup>  74	Name and Address assahn File Belair	ineral Rd. B	Home altimore	, Md	. 21236	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each in	i the death. I							Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a.	neve	ahi	cano					7 months
	/Medical Examiner		Due to (or as	a consequen	nce of):						
		ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	a consequer	nce of):						
<b>√</b>	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	a consequer	nce of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	alE	200.10 (01 43	w consequen	100 017.						
	tificate g phys as the	ledical	0.								
Вох	uth cer tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome	2 Fetal de	eath 3	Ectopic pregnanc	/			23d. Date of o	delivery Day Year
	requires that the death certineen signed by the attending hould be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	t time of deat	th 5□	Other (specify) _					,
, P.O	res that the de signed by the a	by Ph	Part II. Other significant conditions contributing to death b	ut not resultir	ng in the u	nderlying cause giv	en in Part I.	23e. Dio	i tobacc	o use contribute	to the cause of death?
rds	w requires been sign should be	ed b						_ 10	] Yes	2 <b>√</b> No 3□	Probably 4 ☐Unknown
9	has be	Completed						24a. Wa	opsy	. prior t	autopsy findings available completion of cause of
<u> </u>	iclan: The l certificate ha rector, page							1□ Yes		death No 1 ☐ Y	es 2□No
Zit.	Physiclan: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ent 2∏ER	3/Outnatier	nt 3 DOA Oth	or:	Death <i>(Check only</i> ig Home 5		6 DOther /S	nacify)
JO.	nding Physiclan: th. : After this certifica e funeral director, p		27. Man r of Death 28a. Date of Inju	iry 28	8b. Time o			-		jury occurred	poonly/
sior	Attending r death. ector: After by the funer	catio	2 Accident investigation			M 1□	Yes 2□No		(0)		
Division or Vital Records,	or Atl after d Direct in by	Certification:	determined Zoe. Flace of III	iury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location City or 7	own, St	and Number or ate)	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Pertifying Physician: To the best	of my knowle	edge, deat	h occurred at the ti	me, date and p	lace, and due to the	ne cause	e(s) and manner	as stated.
	the Ho in 24 t the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner st		n and/or in			occurred at the tim			
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. Licens	e number 469 89	c.		Date signed (Mo	
	intl		30. Name and address of person who completed cause of c	death (Item 2	3a) (Type		1070	Ø		1	
	1.0		RIMA COUZI, 7501 Osler			uti lo	L, To	nosw.	40	2120	4
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	Regist	ar	мдү 2 3 2008	es B	G	MAN S					

DHMH 17 Rev 1/2001

## Amend #11,19a. per Inf 9887 1/26/09 TT Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 17, 2008 19:55 Richard G. Allison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery General Hospital Montgomery Olney If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Hours Months 1 X M 2 □ F Dec. 9, 76 577-42-2324 1931 Washington, D.C. Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2K No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9904 Derbyshire Lane 20817 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½Yes 2□ NoKorean If Yes, Give Year or Dates: Conflict 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Parking Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Eliza Jones James Robert Allison, Sr. 19a. Informant's Name/Relationship (Type. Print) Ex-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I 9904 Derbyshire Lane, Bethesda, Maryland 20817 Anita F. Allison / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Montgomery Crematorium, Inc. May 21, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart bilure. ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** organ /Medical Due to (or as a consequence of): Examiner (DS15 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed olea that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) signed by the a 1 □ Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Adenocarinom performed After this certifica funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1. Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024190 20+1 30. Name and address of person who completed caus and death (Item 23a) (Type, Print) #205 Woodward 3416 0 landa 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 23 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 20, 2008 Physician 9:00 P. Betty Jean Adamski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore 4403 St. Thomas Avenue 8. Date of Birth 12-26-1935 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours West Virginia Months Days 1 □ M 2X F 72 236-54-6611 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21206 4403 St. Thomas Avenue Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No "natural", or Specify. à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) The Bridge Restaurant Waitress of Health and Mental Hygi item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Unknown Virginia Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21206 4403 St. Thomas Avenue David Adamski - Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iten
any injury or oth 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 05/23/2008 Towson, Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup> Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses mistra 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANCER UTERINE Immediate Cause (Final YEARS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Hospital or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 其 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2.2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27, Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) MAY 2 3 2008

3 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Costs

D43934

PLACE

BALTIMORE MO

C. Spines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Mary G. Butler 5-21-2008 9:30a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ouail Run Asst. Living Balto.Co. Parkville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1-6-192.7 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1 □ M 2 □ F 216-20-0502 Director 81 Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2☐ No Md. Balto.Co, Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Cedar Ridge Ct. 21087 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐Yes 2 🛣No Specify: White p.rmit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", c any injury or other traumatic event, the Medical Evangone. Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Mantini Philamena Caprarola ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John T. Butler</u> 12 Cedar Ridge Ct. Kingsville, Md. 21087 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 5-24-2008 4 ☐ Donation 5 ☐ Other (Specify) Balto. Md. 21. Signature of Funeral Service Licensee 9705 Belair Rd. 22. Name and Address of Facility Schimunek Funeral Homes, INC Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ∐Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner eath After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Cuntural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division of Vital Records. within 24 hours after death To the Funeral Director:

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

Registrar'e Signatu

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place Dundalk MD 21222

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainment. **Physician** /Medical Examiner

CORNELIUS

Division or Vital Records, P.O. Box 68760,

BLACKLEDGE

Physician

/Medical

10a. State

Examiner

**Funeral** 

Director

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Director

Funeral

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Completed

Be

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death with the Maryland

the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. within 24 hours after death To the Funeral Director:

	Convention list conditions	b. Dep 515					10 4445				
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. End Stage Due to (or as a consequence)	1 year								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown										
δ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlyin	g cause given in Part I.		o use contribute 2 □ No 3 □ F	to the cause of death?  Probably 4 Unknown				
Completed					24a. Was an autopsy performed 1∐ Yes 2X	prior to death?	autopsy findings available completion of cause of s 2 No				
Be	25. Was case referred to medical										
0	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 □	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Sp	pecify)				
ation: T	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred					
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac y)	tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.									
M	29b. Signature and title of certifier			29c. License number	Date signed (Mo	nth, Day, Year)					

Registrar DHMH 17 Rev 1/2001

State

900 caton Avenue

P22002

Baltimore

05/22/2008

21229

MD

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radhika Kalisetti

31. Date filed (Month, Day, Year)

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 917 Crawford Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Y 6. Sex 7. Age (In vrs. last hirthday **Funeral** Year, Months 1 □ M 2 🗓 F 76 Yrs 1931 Director 215-74-1130 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10h County 10c. City, Town or Location Examiner : sust be notified at Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 917 Crawford Drive 20851 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 Bus Attendant 18 Mothor's Name (First Middle Maiden Surname)
Phifita Potella
Phifita Potelle 17. Father's Name (First, Middle, Last) Be Leon Creighton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Bernadine Bocus/Daughter 20805 Estates Drive, Bayside, NY 11360 other 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue 21. Signature of Funeral Service Licensee M01346 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Carcinoma of the Salivary Gland /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusi to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month 5 Other (specify) P.O. 9 Unknown uis certificate has been signed it director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2**X** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After s after dea... 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide

and manner stated

2008<sup>32.</sup> Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerard, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 1tem 18 per fh 6880 6-6-08 vt
State of Maryland / Department of Health and Mental Hygiene
amend #18 Per FH G880 6/02/08 JH
Reg. No. 2 0 0

2. Date of Death

May 19,

2008

3. Time of Death

Birthplace (State or Foreign Country)

Trinidad/Tobago

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 ☐ Yes 21 No

29d. Date signed (Month, Day, Year)

May 20, 2008

1 X Yes 2 □ No

11:14 P M

State Registrar

5

For State Registrar

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

Christina Gloria Bocus

within 24 hours a

Medical

29a. Certifier

(Check only one)

Robert H.

31. Date filed (Month, Day,

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0055522

1500 Forest Glen Rd., Silver Spring, MD 20910

			For State Registrar	State of Marylan	Ce	rtificate of	Death	iemai i iy	Reg. N		16/98
	Physici	ian	1. Decedent's Name (First, Middle, La					2. Date of Do Month	D:	ay Year	3. Time of Death
12	/Medi	cal		G. Bremer		# 00 T		May	20	, 2008	7:45 A <sup>M</sup>
7	Examir	теr	4a. Facility Name (If not institution, given Casey House	e street and number)			or Location of Death		_	c. County of Deat	
47 miles	Funeral Director		5. Social Security Number 213-22-7692 Usual Residence of Decedent	7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i> 7. Age ( <i>In yrs.</i>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D October	nth ay, Year 13,	9. Birt 1928 Mar	hplace (State or Foreign untry) yland
	/land ow at		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	a-f sh	Director	Maryland Montgo	mery		Chevy C	hase				1 X Yes 2 □ No
	ith the		10e. Street and Number			10f. Zip Code				itizen of What Co	•
	ath w	E	3606 Faircastle I				20815			ted Stat	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: if item 27 is merked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🖾 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
5-0	72 ho 'natu dical	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	ing	16b. l	Kind of Business/	Industry
121	within	du.	Elementary/Secondary (0-12)	College (1-4or 5+)	1	<i>DO NOT use retire</i> L <b>stici</b> an	d)		Fe	deral Go	vernment
d 2	filed \ Hygie Ither I	ပိ	17. Father's Name (First, Middle, Last		Deaci	LISCICIAN	18. Mother's Name	e (First, Middle			Veriment
Maryland	should be f and Mental I s merked of umatic evel	To Be	William Gunther	•			Mildre			,	
ary	shou and M s mer umat	-	19a. Informant's Name/Relationship (	Type. Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Numl	ber, City	or Town, State, 2	Zip Code)
	and 2 seith a n 27 la		John D. Bremer/So	n	710 F	Hartford	Drive, Bo	ulder,	Col	orado 80	305
Baltimore,	. Pages 1. Iment of He tent: if Iten Jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special	(y) Mont	gomery (	osition (Name of matory or other pla Crematorium	, Inc 2008	21,	Bet		Maryland
Ball	Departr Departr Importe any inju		21. Signature of Funeral Service Line  (M) (C) (C) (C) (C) (C) (C) (C) (C) (C) (C	M01305	Ro 75	2. Name and Addre bert A. Pur 57 Wiscons	ess of Facility iphrey Funer in Avenue, B	al Home/ ethesda,	Beth Mary	esda-Chevy yland 2081	7 Chase, Inc. 4-3501
	Physician /Medical		23a. Part1. Epter the disease, or com- shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line.  Carcinoma  Due to (or as a conseq	of Ova		ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
426	Examiner	er	Sequentially list conditions, if any, leading to immediate	b							
	ansit A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0							
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	ertific ding p	Mec	IF FEMALE:	00- 1/			•		1		
.O. Box	Physician: The lew requires that the death certificate be executed this certificate has been signed by the attending physician and adjusted or, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	⊒Ectopic pregnand ⊒ Other (specify) _	у			23d. Date of del Month	livery Day Year
Records, P.	juires than signed I	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.				o the cause of death?
CO	ew requir s been s 2 should	Completed						24a. Was		24b. Were au	utopsy findings available
E	The lev	mo						perf	opsy ormed?	death?	completion of cause of 2 □ No
Vital	sician: The certificate har rector, page	BeC	25. Was case referred to medical examiner?		,		26. Place of Deat	1 Yes h (Check only	2 <b>X</b> N one)	io i les	2 1 10
or V	shysic this ce al dire	To	1 Yes 2 No	Hospital: 1   Inpatient 2		IL OLI DOA	ner: 4 Nursing Ho	me 5 Res	idence	6 XOther (Spe	cify) Hospice
	ing After une	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe	how inj	ury occurred	
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		me farm str		Yes 2 □ No	29f Location	(Ctmot o	and Alumba v av D	umi Floute Mumber
Ο̈́	는 무 는 그	ertii	4 Homicide determined	building, etc. (Specif	y)	icot, factory, office		City or To	wn, Sta	ite)	ural Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical C	29a. Certifier  (Check only one)  1  Certifying Pt	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time	e cause( e, date a	(s) and manner as nd place, and due	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. D	ate signed (Mont	th, Day, Year)
			Sul	us		D006	34615		Ma	ay 20, 20	800
	14		30. Name and address of person who Genevieve Wroblev				.1 Road, R	ockvil.	le,	Maryland	1 20855
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa		4		<u>.</u>		<u>-</u>	

DHMH 17 Rev 1/2001

08-03841 Patricia Burkhardt

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16799

atriola Burkriarat		-For State Certificate of Death	Reg. No		
Physician		1. Decedent's Name (First, Middle,Last)	ate of Death onth Day	Year	3. Time of Death 0350 hrs
ledical Examine	r	Patricia Joann Burkhardt	y 20, 2008	c. County of Death	
	4	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	*	c. County of Death	
		St. Agries i lospital	Date of Birth/MM	V/DD/YYYY) 9. Birt	hplace (State or
Funeral	5	Months Days Hours Min.		Foreig	n untry) MD
Director		213-80-5411 1 M 2 F 47 Yrs.	02/25/	1961	,, [1]
	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. inside City Limits
w any	1	Tob. Sound			1 Yes 2 No
Aaryland 28a-f show 1 at once	٦,	MD Anne Arundel Pasadena	10g. C	itizen of What Coul	ntry?
the Maryland a or 28a-f sh	ו בו בו	Toe, Street and Number	1.	J.S.A.	
th the Maryland  23a or 28a-f sho  notified at once		257 Asbury Road 21122  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	Yes or No-	14. Race - Amer	ican Indian, Black,
r death with the	E	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rica	n, etc.)	White, etc.	
er de		1  Yes 2  No 3  Widowed 4  Divorced If Yes Give Yeer			ite
5-0036 led within 72 hours afte Hygiewie cother than "natural", the Medical Examiner	େ  -	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)	done 16b	. Kind of Business/	Industry
72 hor na na al Ex	ompiered	Elementary/Secondary (0-12) College (1-4 or 5+)		D 0 T	
036 ithin 73 ne. r than Ledical	림	12 File Clerk  18.Mother's Name (First	- Adiddle Meids	BGE	
For Hygic	اد	17. Fatners Name (First, Micole, Last)			
21215-0036 ould be filed within 7 I Mental Hygiene. I marked other than ie event, the Medica	8	Louis A. Schline, Sr. Joan He	Route Number,	City or Town, State	e, Zıp Code)
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 23a or 28a-f she marked other than "natural".	2	Father			
imore, MD 2121 Pages 1 and 2 should be fi nent of Health and Mental 1 lant: If item 27 is marked or other traumatic event,	+	20b. Place of Disposition Day Deaders, Day Deaders, Day Deaders of Disposition (Name of cemetery, Day Deaders)	ate 20	c. Location - City o	r Town, State
Baltimore, permit. Pages I an Department of Hee Important: If ite	1	1 Burial 2 Cremation 3 Removal from State crematory or other place)	3/08	Clan Bu	rnie. MD
t. Pa	-	4 Donation 5 Other Specify: Glen Haven Mem Pk 05/2  21. Signature of Funeral Service Licensee 22. Name and Address of Facility G. J.	Gonce	Funeral	Home, PA
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is in injury or other traumarie.	1	169 Riviera Driv	e. Pas	adena,	MD 21122
Physician	+	23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res	spiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/ /M dical		failure. Lest only one cause on each line.  Immediate Cause (Final disease a. Diabetic ketoacidosis			Death
aminer	1	or condition resulting in death)  Due to (or as a consequence of):			
	.	Sequentially list conditions, b.			_
	<u>[</u>	if any, leading to immediate  output  Due to (or as a consequence of):			
wb -	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
recuted - transit		d			<del> </del>
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760 cate to physi			v	23d. Date of delive Month	Day Year
Sox 687 feath certific e attending   for use as t	Physician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnants 4 Pregnant at time of death 5 Other (Specify)			12
30X death e atte	ysic	1 Yes 2 No 9 V Unknown 9 Unknown			to the same of death?
o. H					to the cause of death? robably 4  Unknown
P. res the	Completed by	Chronic drug use			autopsy findings available
rds requir	ete		24a, Was an autopsy	prior t	o completion of cause of
e law e has ge 2 s	Ę		performe 1 Yes 2	r -	Yes 2 No
FR The tiffical or, pa	ပိ	25. Was case referred to medical	iy one)		
/ita	<b>m</b>	examiner?   Hospital: 1   Inpatient 2   FR/Outpatient 3   DOA   Other   Nursing			her:
of \oldsymbol{Of} \leftilde{Of} \rightarrow{Of \oldsymbol{Of} \old	.: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work?	8d. Describe how	w injury occurred	
OD endin sath. or: A	tio	1 Natural 5 Pending 2 Accident Investigation (Wolfish, Day, Teah) 1 Yes 2 No		- d November	Dural Bouto Number City
ViSt or Aft in by	ifica	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2: 3 Suicide 6 Could not be	8f. Location (Str or Town, Sta	eet and Number or te)	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Affending Physician: The law requires that the death certificate be executed within 24 hours after earth.  To the Funeral Threator: After this certificate has been signed by the attending physician and completely filled in by, the funeral director, page 2 should be detached for use as the burial - transit	Certification	4 Homicide determined (Specify)		a) and manner as	stated
e Hos 124 h e Fun letely			ue to the cause( the time, date ar	nd place, and due to	o the cause(s)
To the compl	Medical	and manner stated.		29d. Date signed (	(Month, Day, Year)
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		May 21, 2008	
		Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan			
d		30. Name and address of person who complete Juse of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Ø		rasila Creenberg III.			
St Regist	ate	MANY 2 3 2000 1882 18 18 18 18 18 18 18 18 18 18 18 18 18			

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and I Certificate of Death		iene	008	168	00
	* 50.30	М	Decedent's Name (First, Middle, Last)	2. Date of Deat	h		3. Time of I	Death
	Physici /Medic		Walter Crowley	Month	Day C	Year 8	4:22	PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Universe A Tank  Rel There		4c. Co	unty of Death		
£è.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 01-04-1		Cour	lace (State or try) land	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside Cit	v Limits
	Mary -1 ehc	tor	Maryland Harford Bel Air				1 🗆 Yes	•
	n the	Directo	10e. Street and Number 10f. Zip Code	10	0g. Citizen	of What Cour	try?	
	23a c		702 Athlone Drive 21014		USA			
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- c Rican, etc.)	14.	Race - Americ Black, White,		
30	within 72 hours after death with the Maryland ene. then "neturel", or itame 23s or 28s-f ehow his Madigal Examinar must be notified at	by Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No Specify: Year or Dates:		Sp	ecify:		
212-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind	Whit of Business/Inc		
7 12	thin 7.	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Elementary/Secondary (0-12) College (1-4or 5+)	king			•	
7	be filed withital Hygiene.	Con	2 Stationary Engineer			er Brot	hers	
yland		Be		ne (First, Middle, N		mame)		
_	ges 1 and 2 should be t of Health and Mental If item 27 is marked or or other treumatic ev	ပ္	Ernest Chapman Kather:  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	ine Hudgi		Ctata 7in	Codel	
Z	₽ <b>5 ~ ≥</b>		Michele M. Crowley (Wife)  702 Athlone Drive Bel				C00e)	
e)	s 1 ar f Hea item; other		20a. Method of Disposition 20b. Place of Disposition (Name of			ion - City or To	wn, State	
Ē	Pages nent of nnt: If its ury or o		122 Dollar 2 Coloniation 3 Chamoval noth State	23-2008	Re1	Air, MI	i	
Saltimor	교육관금		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sch					1Air
מ	Dep Impo		Inc. 610 W. Macrha	il Rd Bel	Air	, MD 21	014	11111
	20 等。 數學		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Custom Les time He more hage				Onset and D	eath
	/Medical Examiner		Due to (or as a consequence of):				17.676	W.
		-e-	Sequentially list conditions b.				/ bullet	
2	uted d ansit	m i	Cause (Disease or injury				8 mont	4.
, ,	an and	Examin	resulting in death) Last  Due to (or as a consequence of):					21
0/00,	cate be executed physician and the burial-transit	dlcal	a Marbid Oberty					
Ď	ing pt		IF FEMALE:					
מכא	death certific e attending p id for use as	lan/	23b. Was decedent pregnant on the past 12 months?		23d.	Date of delive	_	ear
j	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					701
Ĺ	The law requires that the ate has been signed by the page 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use	contribute to th	e cause of de	эзит?
coras,	quires in sign	ed by	Anotic Encephalopathy	1 ☐ Ye	s 2 🗆 N	lo 3 ☐ Prob	ably 4. DU	nknown
, ,	aw re	Completed	morbid obesity	24a. Was ar		4b. Were auto	osy findings a	vailable
č	The I	E		autopsy perform	ned?	death?	npletion of ca	use of
2	sian: artifica ictor.	Bec	25. Was case referred to medical examiner?	th Check only one			2010	
5	hysic this call dire	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital:	ome 5 Reside			)	
5	ding F	Certification:	27. Many of Death  1 Natural 5 □ Pending (Month, Day Yeer)  2 □ Accident investigation  28a. Date of Injury (28b. Time of Injury Work?  1 □ Natural 1 □ Yeer 2 □ No	28d. Describe ho	w injury oc	ccurred		
2	death death ctor: y the	flcat	3 Suicide 6 Could not be 28e Place of Injury - At home farm, street, factory office	28f. Location (Str	eet and N	umber or Rura	Route Numb	oer.
Š	al or / s after of Dire	Serti	4 ☐ Homicide determined building, etc. (Specify)	City or Town				0.1
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edlcal (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ca red at the time, da	use(s) and ite and pla	d manner as st ice, and due to	ated. the cause(s)	
	To the vithin comp	Ň	29b. Signature and tifle of certifier 29c. License number	29	d Date si	gned (Month,	Day, Year)	
			D 6722	5	5/	19/20	08	
	12			1201	l	Marc	G.b	ber
	Star Registra		31. Date filed (Month, Day, Year)  MAY 2 3 2008  MAY 2 3 2008					
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Juanita Zelma Coard Marth Da2008 Year 19 11:42am M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🖵 F 212 40 4277 86 Maryland 9/22/1921 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Baltimore Landsdowne 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 5th Avenue 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2 \( \text{NW X} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify. 3 ₩ Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ze1ma William Love 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4323 Annapolis Road Baltimore, Md. 21227 Jane Potrzuski daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖒 Cremation 3 ☐ Removal from State 5/23/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland <u>Bavview Crematory</u> 22. Name and Address of Facility McCully Polyniak Funeral Home 21. Signature of Foneral Service Licensee 130 E. Fort Avenue, Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to for as consequence of) Sequentially list conditions, if any leading to minded cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28d. Describe how injury occurred

Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit physician the burial attending pl signed by the a d be detached for

has page 2 s

certificate

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After

within 24 hours after deatl

To the Funeral Director:
completely filled in by the

death.

To the Hospitai

funeral director,

Examiner

Physician/Medical

Completed by

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Medical Certification: To

**Physician** 

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ir than "natural", or items 23a or 28a-f shor the Medical Examinar must be notified at

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e filed within 72 hours after at Hygiene.

Pages 1 and 2 should

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and

Mary

Baltimore,

Division of Vital Records, P.O. Box 68760

/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 21 No 9 Unknown

30. Name and address of person who correleted cause of death (Item 23a) (Type, Print)

1 ☐ Yes 27. Manner of Death 1 Natural 5 Pending

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

23 2008

investigation

determined

6 Could not be

Registrar's Signature

202 W. MAPLE RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8-03685 2008 5802 State of Maryland / Department of Health and Mental Hygiene onna Rosemarie Campbell-Powell Certificate of Death 1- For State Reg. No. 3. Time of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day 1 May 14, 2008 Rhysician/ 1032 hrs Campbell-Powel Examiner Rosemarie Me 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson 1630 Alston Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Min Months Days Hours Country) Jamaica 68 12 39 Director 1 M X F 218-08-7068 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10b. County 10a. State 1 Yes 2X No Baltimore Towson Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A គី 21204 1630 Alston Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-2. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Black Yes XX No Specify: 1 Yes 2 No specify: If Yes, Give Year Widowed 4 Divorced 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore County Claims Adjuster 4yrs 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Desna Wallace Aston Campbell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) ۵ 21204 1630 Alston Road, Towson, Md Lewin Powell-Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Md Baltimore Co, 5/24/08 Woodlawn 4 Donation 5 Other Specify: 22. Name and Address of Facility gnature of Funeral Service Licensee , 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, March Figure 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ignature of Funeral Service License 21215 Approximate Interval Between Onset and vsician failure. List only one cause on each line. Death **Jedical** a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the llospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical XAMEADED perFH, g879 5/23/08 TT UNPENDED attending physician for use as the burial -23d, Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 by the atte 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a. Was an page 2 should prior to completion of cause of autopsy death? performed? certificate has 2 No 1 🗸 Yes 1 ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical director, Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Scene Be Hospital: examiner? DOA ER/Outpatient 3 Inpatient 2 this 1 V Yes No ۵ 28d. Describe how injury occurred 28c. Injury at Work? After the funeral of 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death Subject was assaulted Certification: FOUND: 1 Yes 2 V No 1 Natural Pending May 14, 2008 1002 hrs hours after death. To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1630 Alston Road, Towson, MD Could not be 3 Suicide determined (Specify) Single Family Home 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 24 and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 15, 2008 O.C.M.E. m 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ling Li, MD

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Registrar

31. Date filed (Month, Day, Year) MAY 23

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 810 MARY J. CURTIS nau 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A maryland General Dital Dete of Birth (Month, Day, Year) 4-20-1923 5. Social Security Number 7. Age (Irryrs. last birthday, If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🙀 F MARYLAND 85 212-22-507 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notifiled at 1√Yes 2 No MD, Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 740 POPLAR GROVE ST. 21216 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Ihamany injury or other trainments. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
-12-College (1-4or 5+) SUPERVISOR LAFAYETTE SQUARE LAUNDRY Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AUTHUR JACKSON BEATRICE CALHOUN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEATRICE THOMAS-WARD (DAUGHTER) 3419 RIESTERSTOWN RD. BALTIMORE, MARYLAND 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State MT. ZION CEMETERY 5-28-2008 BALTIMORE, MARYLAND fs □ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licens VERNON BAILEY 22. Name and Address of Facility BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ronar **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an was a... autopsy performed? Yes 2 2-No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 (Xnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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32. Registrar's Signature

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BALTIMURE ST. BALTIMURE, M.D. 21222

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 19 2008 MAY MARJORIE CLAYVILLE 11:14A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOVE HOUSE - HOSPICE WESTMINSTER CARROLL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 07/02/1933 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 K Months Days Hours Min. 218-28-7816 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or items 23a or 28a-f shov edical Examlner must be notified at 1 ☐ Yes 2 No Directo MD CARROLL **HAMPSTEAD** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3933 SHILOH AVENUE 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 🕅 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Year or Dates: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me College (1-4or 5+) SALES RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ABRAHAM WOLFE EDNA KRAMER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES CLAYVILLE / HUSBAND HAMPSTEAD, 3933 SHILOH AVENUE, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State MEMORIAL PARK 1 Burial 2 □ Cremation 3 □ Removal from State 05/22/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part J. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed sician and burial-trans Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the l for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2∏ № 3 Probably 4 ☐Unknown peen £4b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dac House 1 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident al or Attend after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D 29a. Certifier + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

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and title of certifier

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32/Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0.5 16 **Physician** 2:20 AM ALBERT R. CULOTTA 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 17 Little Lane Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 1.XM 2□ F 215 64 53 30 3414 Director 1954 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location ral", or items 23a or 28a-f show Exactiver must be notified at 1 ☐Yes 2 No **Funeral Directon** Md Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 17 Little Lane 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool and Die Maker Chicago Metallic 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Francis Joseph Culotta Marie Grace Mortillaro ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 17 Little Ln Veronica Culotta - wife Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
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Important: If Ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem 05/21/08 4 Donation 5 Dother (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 21122 169 Riviera Dr Pasadena, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760% Exam sician and burial-tran Due to (or as a consequence of) physician the buria Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performe /es 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) rthis c 1∐ Yes 2⊅No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 23 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 11:12H Anthoni 2008 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORD AR 11VR If Under 1 Year / If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 164-26-3560 Usual Residence of Decedent Yrs Director Shenandoah PH permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If fem 27 is marked other than "natural" or therefore the marked other than "natural" or the feature. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Joppa FOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 261 21085 USA enuxod 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No ģ Specify. → Widowed 4 Divorced Specify: Year or Dates White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Queo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည una nthone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21085 nas- Wit 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Na cemetery, crematory or 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL Chasel 22. Name and Address of Facility DR. FOREST H. 11, MD 21050. EVANS FUNERAL Chapol+CLEMATION SERVICES BURIT 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disea le, or combilidations that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of e cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** TRSTATI MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal dea 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 1 I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2. NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours after death. To the Funeral Director: A neral Director: A investigation 1 ☐ Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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82. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** DENTLER 01:50A M GLENN MAT 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 218-90-9516 39 Aug. 20,1968 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🙀 No Maryland | Anne Arundel Directo Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7718 Suitt Drive 21122 Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced White Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Retail Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, to once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Earl W. Dentler Jane B. Brock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane B. Dentler 7718 Suitt Dr., Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 19, 2008 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Catonsville, Maryland Fune | Service Licensee Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Sig 23a. Part1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** ASPIRATION /Medical Due to (or as a consequence of): **Examiner** ANCHTOPENIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed LAIDS and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown MEPATITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No CANCER 24a. Was an autopsy performed? Yes 22 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 7 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours at To the Funeral Completely filled it

3

Registrar

State

MD

29b. Signature and title of certifier

29c. License number

RES 0001

29d. Date signed (Month, Day, Year) MAY, 19, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANDVER ST 1

BALTIMORE, MO 21225

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** BURNELL DAVIS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Sinai Hospital</u> Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 217-20-3148 90 Director 8/31/1917 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10c. City, Town or Location 10a, State Director Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3034 Gwynns Falls Parkway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify African 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced American Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Simon McClurkin Isabelle Boyles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> BO34Gwynns Falls Parkway, Baltimore,MD 21216</u> Carl E. Davis / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 5/20/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home PA of Falto. CO. Mada 9200 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CEREBRIVASULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by D15 EAS & 24a. Was an autopsy performe 1 □ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Manner of Death 28b. Time of

Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOV59107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE 210 BUSINESS CENTER RENSTERSTONN 1 MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

N☐Yes 2☐No

Registrar DHMH 17 Rev 1/2001 **Physician** 

/Medical

10a. State

Director

Funeral

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Completed

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MD

**Examiner** 

**Funeral** 

Director

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the Medical Examiner must be notified at

'natural", or items 23a or

and Mental Hygiene. Is marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lipluy or other traumatic event, once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

al Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnations and all live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 🗌 Ectop	oic pregnancy (specify)		23d. Date of delivery Month Day	y Year
by	Part II. Other significant conditions committed to require itation	acco use contribute to the cause of death?  2  No 3 Probably 4  Unknown					
Completed	mitral regurgitation renal failure, ce	rebrovascula	rdisease	L	24a. Was an autopsy performe	24b. Were autopsy prior to comple death?	etion of cause of
(a)	25. Was case referred to medical			26. Place of De	ath (Check only one)		
P B	examiner? 1 ☐ Yes 2 🛣 No	lospital: 1 Inpatient 2 🗆	ER/Outpatient 3	DOA Other: 4 - Nursing	Home 5 🗆 Residenc	e 6 Other (Specify)	
	- 1 D - 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred	
Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac y)	otory, office 28f. Location (S City or Town		reet end Number or Rural Route Number, State)	
Medical C	29a Certifier 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occur ation and/or investiga	rred at the time, date and plate ation, in my opinion, death oc	ce, and due to the cau curred at the time, dat	se(s) and manner as state e and place, and due to th	d. ne cause(s)
Me	29b. Signature and title of certifier		_	29c. License number	290	. Date signed (Month, Day,	Year)

State Registrar

Towsle 32 Registrar's Signature MAY 2 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kes-000

21

600 North Wolfe St, Baltimore, MD, 21287

May

2008

within 24 hours a

To the Funeral C

completely filled

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:05P<sup>™</sup> George C. Dilli 2008 May 21 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Towson der 1 Year | If Under 24 Hrs. Gilchrist Hospice Center <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1**.2**€M 2□ F Months Days Hours Yrs. 215.30.8003 09.11.1935 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Modical Exactions. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Baltimore Towson MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8434 Charles Valley Ct. 21204 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces:
1 Extes 2 □ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐ Specify: Specify: White 3 Divorced 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Executive Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Dilli, Sr. Mary Dilli Hancke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Dilli/Son 639 Sussex Rd. Towson, MD 21286 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Chesapeake Crem. 05.23.08 |Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee Due Rette P.A. 8717 Green Pastures Dr. Balto., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nemensha Immediate Cause (Final ntacrania Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): montas **Examiner** MCHISTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transi the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 🗆 No 1 ☐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Waspill 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ocmpletely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

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DHMH 17 Rev 1/2001

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AANOW J. CHANNES NO 6701 A. Chanks St TONSON NO 21204

32. Registrar's gignature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 5:50 PM harles ma 2008 ierm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore If Under 24 Hrs. 8. timore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 M M 2 □ F Director 1946 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I've Madical Evaminer must be notified at 1 ☐ Yes 2 THNo **Funeral Director** ND altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 4214 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ene. than Elementary/Secondary (0-12) College (1-4or 5+) Hmtra Ingineer 12 nd Mental Hygie marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o harles ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Manorwood Drive Glen Arm MD 2105 aurel Lierman-Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel & Crematory Syrs - Bellium Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or injury or 5/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 22. Name and Address of Facility
Evans Puneral Chapei & Cremation Services 21. Signature of Funeral Service Licenses 18800 Harford Road Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician - a molicutions one year disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Ye ar Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Records, 2 sign 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an performe certificate 2 🗆 No 1 Yes of Vital Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) mother's Other: 4 Nursing Home 5 Residence 6 Other (Specify) nome Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification; To this funeral 28b. Time of Injury 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation or Attending 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the To the within 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

lot

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carlson M) 65011
32. Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b, c per fh e880 6-2-08 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Frye 07:40 AM **Physician** an 21 Mau 3008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayview Medial Center Baltimore Johns Hopkins Birthplace (State or Foreign Country) 6. Se 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 03 58 MD Director 218-64-2132 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 XYes 2 No Baltimore NA Director MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 72 hours after death with U.S.A. 21224 836 Eastdale Road Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the M other than Tractor Trailer Driver Trucking Company 12th grade 4vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Arlen Frye Leon Henderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 836 Eastdale Road, Baltimore, Md Brenda Frye-Wife 20b. Place of Disposition (Name of King Methoria) other place)
Arbutus Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/08 Arbutus, 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute respiratory distress syndrome veck **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): V Significations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Preumonia The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Stroke Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Day in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No ed by the Division or Vital Records, P.O. 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No 1∐ Yes Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 💢 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Medical Voctor Kes - 000 May 21,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Medical Doctor

Registrar DHMH 17 Rev 1/2001

State

El: Bortz

31. Date filed (Month, Day, Year) 2008

4940 Eastern Avenue

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (\_ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:03PM 2008 May 20 REBECCA JANE DEL FRATE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex Days **Funeral** Months Hours 1 □ M 2 🖫 F Feb. 5, 1925 West Virginia 83 Director 235-30-1199 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Aberdeen 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21001 1820 Park Beach Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No ģ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eveni Be Ada Louellen Frush Albert Nelson Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2924 Del Lembo Drive, Forest Hill, MD 21050 of Disposition (Name of Date 20c. Location - City or Town, Sta Janine D. Lembo / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State St. George's Episcopal 5-24-08 Aberdeen, Maryland 5 ☐ Other (Specify) 21. Signature of neral Serv 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final **Physician** disease or condition resulting in death) tic /Medical Due to (or as a ronsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a conseque Examiner sician and burial-transit be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Yes 2 No P.0. signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 28 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy performed? certificate has 2 No 2 □ No 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 **S**ppatient 1 🗌 Yes ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 546 To the Hospital or Attending Ph 27. Manner of Death After 1 Certification: Injury 1/2 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours al

To the Funeral C

completely filled i 1 (2) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Chesapegha 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MD DSON 7 32. Pajstrar's Signature 31. Date filed (Month, Da). Year)

State

Registrar

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2008

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08-03823 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Leslie Lignelli Gerwig State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Month Day May 19, 2008 Leslie Lignelli Gerwig Medical Examine 0628 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 12865 Linden Church Road Clarksville Howard 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 217-86-2523 43 Months Days Hours 06/13/1964 М Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Clarksville Maryland 1 Yes 2 X No or items 23a or 28a-f shormust be notified at once. carumore, MD 21215-0036
pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other those injury or other traumets. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12865 Linden Church Road 21029 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. Yes White Yes 2 X No specify: 3 Widowed 4 Divorce f Yes, Give Year Specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Office Manager Excavating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nancy Olson Alfonso D. Lignelli 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12865 Linden Church Rd. Clarksville, MD 21029 Michael W. Gerwig/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Christ Fpiscopal Church Cemetery 5/23/2008 1 XBurial 2 Cremation 3 Removal from State Columbia, MD Donation 5 Other Specify 22. Name and Address of Facility. Haight Funeral Home & Chapel. P.A. P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service License 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical Probable pneumonia complicated by oxycodone intoxication Death -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any keeping to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Dans 2 should be sh (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED 7, & 28a-f per ME g881 7/2/08 TT IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 ✔ Unknown pleted 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other; ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Natural Pending Yes 2 X No Fnd 5/19/08 Fnd 6:00 am unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Columbia, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide (Specify) health care facility 5755 Cedar Lane Rm. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

a

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001 OCME 2006 Assistant Medical Examiner

32. Registrar's Signature

السيحارات

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 20, 2008

30. Name and address of person who completed cause of death (Item 23a)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Amend #18, perFH, g879 5/30/08 TT Certificate of Death 0 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1<sup>Day</sup>, **Physician** May GORRICK Sr. 2008 22:55 WILLIAM D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Harbor Hospital Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. | 14, 1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland 1 M 2 □ F Yrs. 79 217-24-7834 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Brooklyn Park Maryland Anne Arundel Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hyglene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21225 U.S.A. 5801 Park Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 Is marked other than "natural", or items traumatic event, the Medical Examiner mi 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Business Owner 10 Ω 18. Mether's Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Gorrick Lillian -19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is any Injury or other trau 5801 Park Road, Brooklyn Park, Maryland 21225 Shirley E. (Wife) Gorrick 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Glen Haven Mem. Park: 05-22-08 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home P.A. 21225 237 East Patapsco Avenue, Baltimore, Maryland Krino 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shr ik, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Weeks imme to te Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner 2 Weeks Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Nonknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Renal Failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s perform 2 No 25. Was case referred o medical examiner? 26. Place of Death Check onl one director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

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State Registrar

Muneer M.D Afroze\_ 31. Date filed (Month, Day, MAY 23 2008

29b. Signature and title of certifier

32. Registrar's Signatur

ull

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

901 E. Fort Avenue, Baltimore, Maryland 21230

DU5105

May 20, 2008

			1 - For State Registrar	State of Ma	aryland		artmen rtificate				lental Hy	/gien	0000	16810
т	Physic	ian	1. Decedent's Name (First, Middle, La	ast)							Date of D     Month	eath Da	ay Year	3. Time of Death
	/Medi		Lillian			Ge	rsoni				April	24.	2008	11:40 A <sup>M</sup>
>	Exami	ner	4a. Facility Name (If not institution, gi				4b. City,	Town, o	r Location	of Death		40	c. County of Death	
			Brighton Gardens 5. Social Security Number 6.		je (In yrs. la:	st hirthday)	Chev If Under		lase If Under	24 Hrs.	8. Date of B		lontgomer	y blace (State or Foreign
1	Funeral Director			1□M 2 <b>X</b> 2F	94	Yrs.	Months	Days	Hours	Min.	(Month, D Mar. 1	ay, Year	914 New	ntry)
	D		Usual Residence of Decedent								rial. I	9, 1		
	arylar show dat	_	10a. State 10b. County			Town or Lo								10d. Inside City Limits
	he M.	ecto	Maryland Montgo	mery	Che	vy Ch	-							1 X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show myn hjury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 5555 Friendship				10f. Zip						itizen of What Cou	ntry?
	er dez	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 24	Ever in U.S.	. 13.	Was Deced If Yes, spec	lent of H	lispanic On an, Mexica	igin? (Spen, Puerto	ecify Yes or N Rican, etc.)	0-	<ol> <li>Race - Americ Black, White,</li> </ol>	
036	urs afte al', or I Examir	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 24 No If Yes, Give Year or Dates:			1 ☐ Yes 2 No Specify:			Specify:			White	
5-0	72 ho natui	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usua kind of wor	l Occup	ation	t of worki	ina	16b. F	Kind of Business/In	dustry
Maryland 21215-0036	filed within 7 I Hygiene. other than "r ent, the Med	ompl	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of wor DO NOT us emake		i)		9	l I	lome	
þ	other other	Be C	17. Father's Name (First, Middle, Las	")					18. Mothe	er's Name	(First, Middle	e, Maidei	n Surname)	
/lar	should be fand Mental I	To E	Albert Levy						Fran	nces	Lewis			
lan	2 sho and 1 is ma	ľ	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailii	ng Address	(Street	and Numb	er or Rura	al Route Num	ber, City	or Town, State, Zij	Code)
	and lealth m 27 her tr		Diane Gersoni Ed						ı St,				NY 1007	
Baltimore,	Pages 1 nent of H ant: If ite		20a. Method of Disposition u1 1 ☐ Burial 2 ☐ Cremation 3 [		unk <sup>er</sup>	ice of Dispo metery, crei	sition (Nam matory or o	ne of ther plac	ce)		Date	20c. L	ocation - City or To	
貰	it. Pa rtmer rtant: njury		4 Donation 5 Other (Speci				N N1	4.6.4.4					Washingt	
Bal	permit. Departr importa any inju		21. Signature of Funeral Service Lice	) )									's Sons gton, DC	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each li	the death.	Do not ent	er the mode	e of dyir	ng, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Alzhei	mer's	Dise	ase							Onset and Death Years
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								
		<u>_</u>	Sequentially list conditions,	b. — Due to (or as	a conseque	nce of).								
	uted Insit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	500 10 (61 40	u oonooquo									
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9	rtifica ng ph as th		IC CCHALC.											
Box	eath certific attending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □Ectopic pregnancy					- 5	23d. Date of deliv	,			
	the at	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of dea	ith 5	Other (spe	ecify)					Month	Day Year
P.0	ires that the de signed by the a be detached		Part II. Other significant conditions	contributing to death b	ut not resulti	ina in the u	nderlying ca	use aiv	en in Part I		23e. Did	tobacco	use contribute to t	he cause of death?
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Records,	w requir	Completed									24a. Wa	e an	24h Woro auto	ppsy findings available
Re	The lay	d L									auto	opsy formed?	prior to co	mpletion of cause of
Vital		a	25. Was case referred to medical						26 Place	of Death	1  Yes 1 (Check only	2 (XN)	o 1 ∐Yes	2 □ No
<u>&gt;</u>	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	ent 2∏EF	R/Outpatier	it 3 □ DO	A Oth	or:				6 ☐Other (Specia	fv)
10 L			27. Manner of Death 1 △ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 2	8b. Time o		Bc. Injur Worl			28d. Describe			<i>y</i> /
Sio		atio	2 ☐ Accident investigatio	n	, roal,	jury	М		Yes 2	No				
Division	- e e	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At hom c. <i>(Specify)</i>	e, farm, str	eet, factory,	, office		2	28f. Location City or To	(Street a own, Stat	nd Number or Rure e)	al Route Number,
	To the Hospital of within 24 hours aft To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)  1 ☑ CertIfying Pl	nysician: To the best of miner: On the basis of and manner sta	f examinatio	edge, deatl on and/or in	occurred a	at the tir	me, date ar opinion, dea	nd place, ath occurr	and due to the ed at the time	e cause(s	s) and manner as s nd place, and due t	stated. o the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier	116	(	7			e number				ate signed (Month,	
			· Michae	11/1	rod	9		)159	0			Apr	il 25, 20	008
			30. Name and address of person who Michael J. Grady				,	J #1	14W W	ashi	ngton,	DC	20016	

Registrar

State

31. Date filed (Month, Day, Year)

MAY 2 3 2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 20, 2008 **Physician** ам Dorothy Louise Murr Giardina 10:20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hillside Assisted Living Clarksville Howard B. Date of Birth (Month, Day, Year) 06/11/1920 Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1 □ M 217 F 87 Maryland 219-07-4328 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 XNo Ellicott City Director MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number iral", or items 23a or Examiner must be 21042 United States 10396 Lombardi Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Police Department marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Olga C. Rothe Albert G. Keck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10396 Lombardi Drive, Ellicott City, MD 21042
se of Disposition (Name of Date 20c. Location - City or Town, State Mr. Ronald Murr (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/23/2008 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Man T. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIO PULHONORY /Medical Due to (or as a consequence of): Examiner Corro ICanal to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hyperteumon death certificate be executed and I-trar Due to (or as a consequence of): physician at s the burial-t P.O. Box 68760 Physician/Medical ası the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown ρ 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ AL2 HEIMER'S DEMENTIA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed OSTEO ARTHRITIS. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No has autopsy performed certificate 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be HSSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 22, 2008 30469

State Registrar

100 PARKUMY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.B. VELLANKI 8850, COLUMBIA IC

Registrar's Signature

N.B. VELLANKI

31. Date filed (Month, Day, Year) MAY 2 3 2008

# 308 Columbia, MD 21045

			1 _ State	of Maryland / Dep	artment of F		, ,	0000	10010
		m	Registrar  1. Decedent's Name (First, Middle, Last)		Tuncale of I	Deain	Reg. 2. Date of Death		3. Time of Death
1	Physic /Medi		Jacqueline Rhea	Griswold			MAY 2	21,2008	1:40 PM
	Exami	ner	4a. Facility Name (If not institution, give street and Carroll County General		4b. City, Town, or Westm	Location of Death		4c. County of Death	
	Funeral		Social Security Number	7. Age (In yrs. last birthday,	If Under 1 Year		8. Date of Birth (Month, Day, Ye	Carroll 9. Birthp	lace (State or Foreign
	Director		217-54-3554 1 M 2 M	56 Yrs.	Months Days	Hours Min.	10/30/19	51 Mary	
	yland ow at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	e Mary Ba-f sh tified	ctor	Maryland Carroll	New Wind	dsor				1 □Yes 2 No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	Funeral Director	10e. Street and Number   15049 B New Windsor Ro	oad	10f. Zip Code 21776	5	_	. Citizen of What Coun United Stat	•
	r deati	uner	Armed	ecedent Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race - Americ Black, White,	
36	ırs afte al', or il xamln	ğ	1 Never Married 2 Married 1 7 You	es 217 No	1 ☐ Yes 2 No	Specify:	, ,	Specify: Whi	
215-0036	72 hou 'natura dical E	Completed	15. Decedent's Education (Specify only highest grade complete	16a. Dece	dent's Usual Occup	ation	168	b. Kind of Business/Inc	dustry
2121	filed within Hygiene. Ither than "	dmc		e (1-4or 5+)	DO NOT use retired cher	during most of workin )		Education	
d 2	be filed ntal Hygi od other event, t	BeC	17. Father's Name (First, Middle, Last)	200		18. Mother's Name			
Maryland	12 should be fi and Mental H is marked ott raumatic ever	To B	Kenneth McCawley			Emma S			
	D # 2 T		19a. Informant's Name/Relationship (Type. Print)  Jerry W. Griswold / Hus	sband 1504	ng Address (Street a 19 B New W	and Number or Rural Vindsor Ro		ity or Town, State, Zip Windsor, MI	
Baltimore,	m ~ =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e) i Da	ate 20d	c. Location - City or To	wn, State
Iţi	Par in in in in in in in in in in in in in		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Loudon Pa		_		altimore, M	<u>1</u> D
Ba	permit. Departr Importa any inji		Maut 2	Hu 41	ibbard Fun 07 Wilken	ss of Facility leral Home Is Avenue	, Inc. Baltimor	re, MD 212	229
			23a. Part1. Enter the disease or complications the shock, or heart failure. List only one cause of	at caused the death. Do not en n each line.	ter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Tic SHOCK / to (or as a consequence of):	MULTIPLE	ORGAN S	ISTEM F	AILURE	Onset and Death
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	ed sit	iner	if any, leading to immediate Due cause. Enter Underlying	to (or as a consequence of):					
Ć,	execut n and ial-trar	Examiner	trial initiated events	HERA LOWER 1 to (or as a consequence of):	EXTREMIT	y DEEP	VEIN THE	ROMBOSIS	
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	d. PAN	CREATIC CAR	RCINOMA				
	leath certificate t attending physic I for use as the b	/Mec	IF FEMALE: 23c, If yes.	outcome pf pregnancy					
Box	death e atter	Physician/M	in the past 12 months? 1□Liv	e birth 2  Fetal death 3 egnant at time of death 5	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			23d. Date of delive Month	ry Day Year
P.0	nat the de d by the etached	Phys	9 Unknown 9 Ur						
	uires tha signed to d be det	þ	Part II. Other significant conditions contributing to Wrinary track		nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to th	e cause of death? ably 4 □Unknown
300	aw requir Is been si 2 should b	olete		U			24a. Was an		osy findings available
or Vital Records,	The atte h	Completed					autopsy performed	prior to con death?	npletion of cause of
Vita	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:		othe Othe	26. Place of Death			
0	ding Phys Tafter this funeral di	n: To	27. Manner of Death 28a. Da	Inpatient 2 ER/Outpatier te of Injury 28b. Time o	" OLI DON	4 LI Nursing Hom	e 5 Residence	e 6 Other (Specify	)
sion	ending eath. or: Aft	ation	2 Accident investigation	onth, Day Year) Injury		? ⁄es 2 □ No		,,	
Division	To the Hospital or Attending Physician: whim 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:		ice of injury - At home, farm, str ilding, etc. <i>(Specity)</i>	eet, factory, office	28	Bf. Location (Street City or Town, S	t and Number or Rural tate)	Route Number,
	lospita hours 'uneral		29a. Certifier (Check only gae)  1 Certifying Physician: To 2 Medical Examiner: On the	the best of my knowledge, deatl	h occurred at the tim	ne, date and place, a	nd due to the caus	e(s) and manner as st	ated.
	o the hithin 24 o the F	Medical	one) and m 29b. Signature and title of certifier	anner stated.	29c. License			Date signed (Month, L	
	- 3 + 8		A. J. Helay M	.4			- N	Jay 21,	2008
•	10		30. Name and address of person who completed ca		Print)	ENTER	WESTMI	INSTER, MI	21157
	Sta								
	Registr	ar	MAY 2 3 2008	Registrar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Waryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** May 18 MODAM 2008 NER GREGT /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner HOME 8. Date of Birth (Month, Day, Year)
8 -18 - 1930 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months Days Min Director Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1. Yes 2 No Funeral Director 10g. Citizen of What Country? 10e, Street and Number filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 √ es 2 □ No I/Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 □ Yes 2 📉 o Baltimore, Maryland 21215-0036 "natural", or Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry or other traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. nset and Death lags Immediate Cause (Final stroke rysician Lemorra resulting in death) ledical Due to (or as a consequence of) Examiner Revetersign Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician the detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 2 - NC Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 THomicide To the Hospital or 1 🖟 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ö MACGREGOR, MISSABELLE BALTIDORE, MD 21211 700 W. 40% STREET, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 3 2008

Registrar

State

strar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year M 700 /Medical 4b. City, Town, or Location of Death
MED CENTER GLEN BURNIE Examiner tution, give street and number WASHINGTON 4c. County of Death BALTIMORE ANNE ARUNDEL Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 216-56-3816 1**∑** M 2□ F 58 Months Days Hours Min 11-16-1949 Director MARYLAND Usual Residence of Decedent 10b. County show 10a. State 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Extrainer interitor inclined at Director MD BALTIMORE DUNDALK 1 ☐ Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3804 EDGEWATER PLACE 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify þ Specify: WHITE 3 Widowed 4 X Divorced Year or Date \$ 968 - 70 Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHAM STEEL MILL WRIGHT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH HOLLAND permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic ev WILLIAM VIRGINIA MARIE (RUDDY) 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20622 7720 CARRICO MILL LANE CHARLOTTE HALL, MD MARK HOLLAND/BROTHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 5-24-08 METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Andisc NS/m /Medical Due to (or as a consequence of): Examiner 1031 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed 25 signed by the attending physician and defacted for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ij 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 □ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

DHMH 17 Rev 1/2001

4231 31. Date filed (Month, Day, State

29b. Signature and title of certifier

Postal

MSAdena 32, Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

もいから

-C. Thomas Folkemer MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month MAY **Physician** 18, 2008 Anna Harle 1:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Long View Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 □ F 219-16-4747 83 Director APR 14, 1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show notified Director 1 ☐ Yes 2 ☑ No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 5922 Hunt Club Road 21075 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married natural", or 3altimore, Maryland 21215-0036 1 □ Yes 2 √ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Stefan Schachnuk Anna Weisingoff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health a 182 Riverview Trail Sykesville, MD 21784 Department of Health Important: If item 27 any injury or other tr Sandy Tyler/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore National Cemetery Baltimore, MD 22. Name and Address of Facility
Haight Funeral Home & Chapel, P.A.
P.O. Box 195 Sykesville, MD 21784 (410-795-1400) 21. Signature of Funeral Service Licensee WOAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimens Physician disease or condition resulting in death) 1ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertainty Cause (Disease or injury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours effer death.

I the Funeral Director After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 👺 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?
Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No Medical Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 -Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19,2008 30. Name and address of person who com (leted cause of death (Item 23a) (Type, Print)

State Registrar 25

32. Registrar's Signature

Mari

ZAEll

31. Date filed (Month, Day,

MD

Reisterston

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State of Waryland / Depart	ficate of Death		g. No.2 0 0 8	16823
idh	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
36.00	/Medic	al	Elizabeth Hensler  4a. Facility Name (If not institution, give street and number)  4	b. City, Town, or Location of Death	may	2) 2008 4c. County of Deat	8 130 PM
	Examin	er	Johns Hopkins Bayview Medical Center	Batimore		40. County of Deal	
4,7%	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2X F 78 Yrs.	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 8-15-192	Year) 9. Birt Co Mo	hplace (State or Foreign untry) 1.
	/land ow at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati	ion			10d. Inside City Limits
	e Mary a-f sh tified	ctor	Md. Baltimore C	ity			1 X Yes 2 □ No
	iff the	Directo		10f. Zip Code	10	g. Citizen of What Co	untry?
	s 23a nust k		921 S. Fagley Street	21224		USA 14. Race - Ame	rinen Indian
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I warked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 🔯 Married   1 □ Yes 💸 🗀 No	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto  Yes 2 X No Specify:	ecity Yes of No- Rican, etc.)	Black, White	e, etc.
5-0	"natu	letec	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give king DO	t's Usual Occupation d of work done during most of work NOT use retired)	king 1	6b. Kind of Business/	Industry
12	within iene. than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Own			Deli	
מַ	should be filed wand Mental Hygies marked other tumatic event, th	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
ylar	Menta Menta arked atic ev	To E	William Thelen	Marie	e Rose	*	
Jar	C/ (0 m ig		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing A	Zip Code)			
	1 and 2 Health em 27 l		20a. Method of Disposition 20b. Place of Disposition	S. Fagley Street		1d. 21224 Oc. Location - City or	Town State
io E	Pages Trent of I ant: If Ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ory or other place) ort of Jesus 5-24		Dundalk,	,
Baitimore,	permit. Pages Department of I Important: If it any Injury or o			ame and Address of Facility	7 2000	Danaark,	
m	De la la la la la la la la la la la la la		off tally s	chimunek Funeral	L Home 97	'05 Belair	Rd.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				
	Examiner		Due to (or as a consequence of):  ACINEO DOCHER	Pneumonia			
10	7 +	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	1/00/1/01/1/01			
3	ecuted and transi	Examiner	that initiated events	DPD			
68/60,	cate be executed physician and the burial-transit		Due to (or as a consequence of):				
/89	rtificate be executed ng physician and as the burial-transit	Medical	d				
O. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ec 4 □ Pregnant at time of death 5 □ Ot	etopic pregnancy ther (specify)		23d. Date of del Month	ivery Day Year
ecords, P.	juires that I signed by Ild be detad	þ	Part II. Other significant conditions contributing to death but not resulting in the under Chronic Kidnly discase	rlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
<del>ဂ</del>	es (2) O. I	Completed	Coronary artery disease		24a. Was an		itopsy findings available
r	sician: The law certificate has l irector, page 2 s	mo	diabetes mellitus type 2		autopsy perform 1 Yes 2	prior to a	completion of cause of 2 ☐ No
VITai	cian: ertifica ector, J	Be C	25. Was case referred to medical examiner?		h (Check only one		20110
2	this ald	P	1  Yes 2 No  Hospital: 1  Inpatient 2  □ ER/Outpatient : 27. Manner of Death  28a. Date of Injury  28b. Time of			nce 6 Other (Spe	cify)
	ng After	tion:	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	Hospi 24 hour Funer stely fill	Medical	29a. Certifier  (Check only one)  One)  Certifying Physician: To the best of my knowledge, death or the basis of examination and/or investigation and manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	Fo the within to the comple	Mec	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	h, Day, Year)
)	,->F0		>/(det/) hurer	RES - 001		05/21/	12008
	10		30. Name and address of person who, completed cause of death (Item 23a) (Type, Prin Robert Duhaney 4940 Ed	it) Auginia	0 11	200	212211
	Sta	to	31. Date filed (Month, Day, Year) 32 Registrar's Signature	NOTITI HVENUE	, Dathi	MOVE, INIL	), 21224
¥	Sta		MAY 2.3 2008 Result 5. 4234				

# Baltimore, Maryland 21215-0036

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month May Bay **Physician** 2008 1545 M Matthew Hall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days **1**√2 M 2 □ F 69 228-48-0083 Director 2**-1**0-1939 VA Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Expinitive Intest be confilled at once. 1 XYes 2 ☐ No Director MDn/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 3328 Havward Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 KMarried 1 □Yes 2 □XNo Specify SpecifyAfrican-American \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehousenan WT Cowan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearlie Wilson William H. Hall ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3328 Hayward Avenue, Baltimore, Maryland 21215 Betty A. Hall/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.ZionCemetery 5-27-08 Lansdowne, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 LibertyRoad, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myccodial
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 □No 1 Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1120 N. Rolling Rd Cartholle Mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

MAY 23

2008

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of State Alegistrar	Maryland / Depa	artment of H			ene g. No2 0	08	16825
	Physici:		1. Decedent's Name (First, Middle, Last)	HEIGH			2. Date of Death Month	2 Day 20	Year 00'8	3. Time of Death 6:55 A M
and a	Examin	- 44	4a. Facility Name (If not institution, give street and number 16. Sex 7	Der) CLLDer Age (In yrs. last birthday)	4b. City, Town, or  Balti  If Under 1 Year		8. Date of Birth	4c. County		aco (State or Foreign
2	Funeral Director		212-32-9783 1 M 2 T F V Supplemental Supplem	72 Yrs.	Months Days	Hours Min.	(Month, Day, 09 04		Count	ace (State or Foreign try) MD
	e Maryland a-f show iffied at	ctor	MD Baltimore	10c. City, Town or Lo	onsville					0d. Inside City Limits 1 ☐ Yes 2☐ No
	th with the 23a or 28 ust be not	ral Director	10e.Street and Number 1335 Lincoln Woods Di	rive	10f. Zip Code 212	28	10		S.A.	
980	be filed within 72 hours after death with the Maryland that Hyglene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Deced Armed Forc  1 □ Yes 2  If Yes, Give Year or Dat	. □ <b>X</b> No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes X☐ No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America ck, White, e v: Bla	etc.
Maryland 21215-0036	within 72 ho lene. than "natur he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  2th grade  College (1-4 yrs	(Give life.	dent's Usual Occupa e kind of work done of DO NOT use retired Teacher	ation during most of work )	<sup>ing</sup> E	6b.Kind of Bi Baltim Public	ore	City
land 2	should be filed vind Mental Hygies marked other umatic event, the	8	17. Father's Name ( <i>First, Middl</i> e, Last)  James Montague			18. Mother's Name			ne)	
	nd 2	0.4	19a. Informant's Name/Relationship (Type. Print) Roscoe Heigh-Husband	1335	Lincoln	Woods	Drive C	Catons	vill	e, Md <sup>220</sup>
Baltimore,	es 1 of F rite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Tremation 3 ☐ Removal from State of the	Green M		5/17		Baltin	•	
Ball	permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service Licensee	4	2. Name and Address arch F/H 300 Waba	sh Ave,			Md	21215 Approximate
	Physician /Medical	0 1	resulting in death)	etastatic.	breast	Call Co	or respiratory arre	st,		Interval Between Onset and Death
8760,	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	r as a consequence of):  r as a consequence of):  r as a consequence of):	hellen	rlage				Sdaips
.O. Box 6	the death certifi y the attending ched for use as	Physician/Med	in the past 12 months?	nt at time of death 5[	□Ectopic pregnancy	,			ite of delive	ory Day Year
<u>α</u>	The law requires that te has been signed by age 2 should be deta	by	Part II. Other significant conditions contributing to dea	th but not resulting in the u	underlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	/	tribute to th	ne cause of death? nably 4 □Unknown
al Records,		Completed		7- 17- 18- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-				ned?	prior to con death?	psy findings available npletion of cause of 2□ No
Division or Vital	ding Phys n. After this funeral dir	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month	, Day Year) Injury	of 28c. Injur World M 1	er: 4 Nursing Ho	ome 5 Reside 28d. Describe ho	nce 6 □Oth w injury occur	rred	
Divi	oital or At urs after d ral Direct		4 ☐ Homicide determined buildin	of injury - At home, farm, st g, etc. <i>(Specify)</i>			28f. Location (Str City or Town	, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  2□ Medical Examiner: On the bar and manual	sis of examination and/or i		pinion, death occu	rred at the time, da		, and due to	the cause(s)
	10		· mazzelle	ATTEULL of death (Item 23a) (Type	elg DS6	399	l	lecey	13,7	8001
1	Sta	ite	J. DATE APOLITICAL STATES AND STA	of death (Item 23a) (Type 50 ST. PAU	L8T.	Baltimo	4,24	212	04	
	Registi	ar	MAY 2 3 2008 See	in it for	ME					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Hall Bernice 23:30 May 20 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital OF BALTIMORE taltimore City 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔽 F Months Days Hours Min. 216-36-4443 70 38 04 16 MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2904 Glenn Ave Apt C 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: Black 3√ Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Nurse Assistance Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William E. Hall Mary Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milton Hall-Son 6904 Sandy Creek Ct., Clarksville, Md 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/29/08 | Woodlawn, Md 21. Signature of Funeral Service Licen 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) 8 days Metastatic Browst JYERTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) TYPS 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Brain TOI 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy performed Stage Renal Disease anz 1 □ Yes 2 🛂 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)

Examiner

Physician/Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Bernice

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Eventher rust be neithed at once.

**Physician** 

/Medical Examiner

> þ Completed Be

State Registrar 29b. Signature and title of certified

29c. License number

RES-000

HOSPITAL OF BAUTIMORE

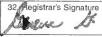
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) May 20, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBBS ROSAS-CALRERON

31. Date filed (Month, Day, Year)

MAY 23 2008



and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh e880 6-13-08 yt. State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year

**Physician** /Medical Examiner

**Funeral** Director

r 28a-f show notified at permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 1

Maryland 21215-0036

Physician /Medical Examiner

physician and the burial-transit that the death certificate be executed as for use a the ģ signed b been signature should be has e 2 page certificate le Hospital or Attending Pl 124 hours after death. In Funeral Director: After the Pletely filled in by the funeral

Division or Vital Records, P.O. Box 68760.

3. Time of Death 2:30 PM Nevayah Destiny Hungerford May 2008 12 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery if Under 1 Year If Under 24 Hrs.

Months Days Hours Min.
2 18 Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) February 24, 2008 Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months 214-81-9726 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 133 Watkins Station Circle, Apt. A 20879 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 ☐ Yes 2 No
if Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Completed by 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julius N. Hungerford, Jr. Porsha E. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Porsha E. Jones / Mother 133 Watkins Station Circle, Apartment A, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State ry Crematorium

Yay 24, 2008

Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,

Rockville, Maryland 20850-2805 4 Donation 5 Other (Specify) Montgomery Crematorium 21. Signatur of Funeral Service Licensee M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Necrotizing Ent Due to (or as a consequence of): Enteracelitis 3 days 262/1 weeks gestation Extreme prematurally pue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Intrauterine arouth retardation

Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal failure, parenchymal brain cyst, intrauterine court 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of setardation, cholestasis, hyponatrimia, hypokationia, sepsio autopsy performed? anemia resouration distress surdrame resouration failure examiner? death? 1 XYes 2 No 2 No To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D50902 May 12, 2008

Registrar DHMH 17 Rev 1/2001

State

A Kimberly Infolia, mo 31. Date filed (Month, Day, Year)

MAY 2 3 2008

within 24 hours at To the Funeral D

completely

Rockville, maryland

9901 medical Contr Drive

32 Registrar's Signature

A CAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Month John Joseph Hook, Jr. 8:17P M 18, /Medical May 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1707 Pin Oak Avenue Dundalk 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 □ F 213-52-3318 Yrs Director 60 Oct. 19,1947 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experient must be notified at Director 1 ☐ Yes 21 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1707 Pin Oak Avenue 21222 Funeral United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√5√No Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Machine Operator Wire Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. Hook, Sr. Doris Lillian Airey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ramona Langford (Sister) 1718 Evergreen Drive Dundalk, Maryland permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns: 5/23/2008 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. ulli 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on wach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Candiquascular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No has 24a. Was an page 2 certificate 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 \subseteq Nursing Home MYes 2∐No Certification: To 1 🗋 Inpatient 2 ER/Outpatient 3 DOA this Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 ☐ Yes 2 □ No within 24 hours after deat To the Funeral Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Y death (Item 23a) (Type, Print) 7. Luthorville, MD Trim 6 nth, Day, Year) 31. Date filed (Mo Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

08-03837 Bre

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hydiene

renda Johnson	1- F	State of Maryland / Department of Health and Mental hy for State Certificate of Death	ygierie Reg	No. 20	08 1682
Physician/	Rec	Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Physician/ ledical Examiner		Brenda Jean Johnson	Month May 19, 200	08	2104 hrs
plan	4a	. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea Anne Arunde	
		Baltimore Washington Medical Center Glen Burnie  Serial Security Number 16 Sex 17 Age (In vrs. last birthday) If Under 1 Year 1 funder 24Hrs	8 Date of Birth	(MM/DD/YYYY) 9. B	
Funeral Director	2	16-68-8407 1 M 2XF 53 Yrs. Months Days Hours Min	_	Fore	country) Maryland
, A	_	sual Residence of Decedent  a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
00 an		Maryland Anne Arundel Glen Burnie			1 Yes 2 X No
aryland 8a-f show any at once,	10	ie. Street and Number	100	g. Citizen of What Co	ountry?
the Maryland a or 28a-f sh tified at one Director	3	307 Main Ave., S.W. 21061	บ	nited Stat	tes
with the same same same same same same same sam		Mantal Status     12. Was Decedent Ever in U.S.     13. Was Decedent of Hispanic Origin? ( S	pecify Yes or No-	14. Race - Am White, etc.	encan Indian, Black,
0036 within 72 hours after death with the Maryland siene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once ompleted by Funeral Director	1	Never Married 2 X Married 1 Yes 2 X No	7 ( o o i i j		White
Fe 7. Fe 7.	시 3	Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	Specify: V	
hours natur Exam		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-	tired)	4 1	
36 in 72 han " dical		4 AssetManager		State Go	vernment
5-0036 lted within 72 hours Hygiene. I other than "natur the Medical Exam Completed	<u> 17</u>	7. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle, M	laiden Surname)	
21215-0036 Muld be filed within 72 hours a Mental Hygienc. marked other than "natura ic event, the Medical Examir	E	Camon Affen neocharen	lay Ziegl	er	ata Zin Codo)
	- 1	9a. Informant's Name/Relationship (Type, Print)  Ralph E. Shaw / Husband  307 Main Ave., S.W.,			1
nore, MD 2 ages 1 and 2 shou nt of Health and h tt: If item 27 is n other fraumatic		20h Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
of He		Removal from State crematory or other place)	y 23, 2008	Elkridge,	Maryland
t. Pag t. Pag tment rtant:		1. Signatur of Funeral Service Licensee			
Baltimore, permit. Pages 1 an Department of Haa Important: If iter injury or other tra	i	1421 Crain Hwy., S.	E., Gler	me, P.A. Burnie,	MD 21061
Physician	2	3a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
- Mudical		failure, List only one cause on each line.  mmediate Cause (Final disease a, Chest Injuries			Death
aminer	C	or condition resulting in death)  Due to (or as a consequence of):			
1	ءِ ا <sub>ا</sub>	Sequentially list conditions, fany, leading to immediate Due to (or as a consequence of):			
		cause. Enter Underlying Cause			
und cuted , and it transit	EXa	events resulting in death) Last  Due to (or as a consequence of):  d.			
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	ᇹᅡ	UNPENDED AMENDED			
		F FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	
687 ertific ding p	an/	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy	Month	Day Year
30x 6876/ death certificate e attending phy	Physician/N	1  Yes 2  No 9  Unknown  g  Unknown		(141)	
ing Physician: The law requires that the de After this certificate has been signed by the uneral director, page 2 should be detached for		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?
Records, P.O. The law requires that th icate has been signed by page 2 should be detach	a P		- 1		Probably 4 Unknown re autopsy findings available
rds requi	ete		24a. Was		r to completion of cause of
ecc he lav ate ha	Completed		1 Yes	2 No 1	Yes 2 No
an: T		25. Was case referred to medical examiner? 26. Place of Death (Che examiner?   Hospital:   Double   Properties   Propertie		1 positioner 6 1	Other:
f Vital Physician:	0	1 V Yes 2 No Inpatient 2 V Ervoupatient 3 Don	rsing Home 5	Residence 6 0	Other.
J of ling P		27. Manner of Death  28a. Date of Injury 1 Natural 5 Pending  28b. Time of Injury 28c. Injury at Work?  28c. Injury at Work? 28c. Injury 28c. Injury 28c. Injury 28c. Injury at Work?  1 Yes 2 ✓ No	Driver auto	auto collision	
ivision or Attencatter death Director:	Cati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.			or Rural Route Number, City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stafter death.  The Invector After this certificate has been signed by the funeral director, page 2 should be detact	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	or Town, Rt. 2 and Rt.	State) 301, Glen Burnie	MD
spi hou fil		700 Certifier	and due to the cau	use(s) and manner as	s stated.
To the within 2 To the complet		one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, dat		
F 3 F 8	<b>ĕ</b>	29b. Signature and title of certifier		May 20, 200	(Month, Day, Year)
01		Mhu Branelle MD O.C.M.E.		Ividy 20, 200	
	İ	30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	MD 21201		
		Wildlied Diagon, in			
Sta Registr		31. Date filed (Month Day, 2a) 2008 32. Legistrar's Signatur			
DHMH 17 Rev 1/20		ORIGINAL			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 2008 **Physician** May 21, 7AM **JAMES** NICHOLAS KRAUTER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Care 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 29, 1912 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. XX™ Mary Land 96 215-01-4723 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanimer must be notified at 1 □Yes 2√XNo Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 515 Wyngate Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No WW I I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 💢 💢 o Specify. White Specify: 3XXWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sporting Goods Dealer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Krautblatter Mary Boblooch Harry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Anne Krauter DTR 4209 Ravenhurst Circle Glen Arm Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gardens May 23, 2008 Timonium MD ☐ Donation 5 ☐ Other (Specify) Ignature of Fun r Certice Licensee 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Mrus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAYS **Physician** GASTROINTESTINAL /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to firm entate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year 5 ☐ Other (specify) 1 ☐ Yes 2 ▼No 9 ☐ Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy 2 **Z** No 1 ☐ Yes 2 ☐ No 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D64395 MAY 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6505 NEHAPLES ST, SUITE 209 BALTMONE, MD 21204 OOBERMAN. DANIEUE MO Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 05-18-2008 338 A Catherine M. Kafer 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Rosedale Manor Care If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04-20-1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Months Maryland 1 □ M 2 🔽 F 90 215-07-7501 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 604 South Clinton St 21224 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sportswear Buyer Retail Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Kremer Henry Kief 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 South Clinton St Baltimore, MD 21224 Kathleen Kafer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Bayview Creamtory 4 ☐ Donation 5 ☐ Other (Specify) 5-20-2008 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each he. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -ILURE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Veal Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death 1 □ Yes 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Denknown

**Physician** /Medical Examiner

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ate has been signed by page 2 should be detack

funeral director,

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To the Hospital of within 24 hours all To the Funeral Completely filled in

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Tyes

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of Injury

Other: 28c. Injury at Work?

26. Place of Death (Check only one) 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manper of Death 1 Matural 2 Accident 3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

determined

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Theck only

TW Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature a

DOOGOSTO MAY

29d. Date signed (Month, Day, Year)

V)

State Registrar 31. Date filed (Month, Day, MAY 2

Registrar's Signature RINGR NEOR RD#109, BALTIMORE, MY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Kuhn 5:14 AM 20, May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2712 Glendale Road Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Hours 216-44-0971 Director 12/02/1945 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expendent must be notified at 10d. Inside City Limits MD Baltimore Director Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 Glendale Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1966 — If Yes, Give Year or Dates: 1971 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify Š Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Post Office Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o 2 should be Walter Kuhn Lillian Gladkowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Judy Kuhn/ Wife 2712 Glendale Rd. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel – Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State ortant: If it Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/23/08 Forest Hill, MD 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immuniate Cause (Final **Physician** yourdial di e se or condition re ting in death) minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Box 68760, Due to (or as a consequence of): ng physician a as the burial Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Pregnant at time of death 5 Other (specify) 0 ☐Yes 2☐No detached he 9 D Unknown 9 Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Flobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 ☑ No 1 □ Yes 2 No or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 💢 Residence 6 Other (Specify) 1 Tes 2 10 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 24 hours after deatl Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only

within 2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of pers

29b. Signature and title of certifier

of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

08-03822 Connor Elliott King Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nnor Elliott King	1- F	State of or State	f Maryland / Departr <i>Certifi</i>	ment of Hea icate of Dea	ith and Mental I th	Reg. No	20	08 1683
Physician/	Red	istrar Decedent's Name (First, Middle,Last)				2. Date of Death Month Day May 19, 2008	Year	3. Time of Death 0640 hrs
edical Examiner		Connor Ell	iott King		- Leating of Do		c. County of Deat	
	4a	Facility Name (if not institution, give s Howard County General Hos			Town, or Location of Dea mbia		Howard	
E	5	Social Security Number 6. Sex	7. Age (In yrs. last	,	der 1 Year If Under 24		Forei	rthplace (State or
Funeral Director	"	219-79-6608	и 2F	Yrs. 6	ths Days Hours 1	Oct.31,	2007 0	ountry) MD
		a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
w any	1	MD Baltimo		iddle R	iver			1 Yes 2 X No
yland once	1	e. Street and Number	11		ip Code	10g. C	itizen of What Co	untry?
ith the Maryland 23a or 28a-f show a posified at once. al Director	"	2167 Firethor	n Road		21220	τ	JSA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygener 7 is marked other than "matural", or items 23a or 28a-f 5he ratic event, the Medical Examiner must be notified at once TO Be Commissed by Funeral Director			12. Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin? cify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,
r death with or items 23 must be no	1	Never Married 2 Married	Armed Forces?			sito Ricali, etc.,		White
her d	<u>ام</u>		f Yes, Give Year or Dates:		No specify:	af work done	Specify: \	
ours after attural" ramine		15. Decedent's Education (Specify only	, mg. met g	6a. Decedent's Usu during most of v	al Occupation (Give kind vorking life. DO NOT use		N/A	,
1036  vithin 72 hours ene.  rr than "natur Medical Exam		Elementary/Secondary (0-12)	College (1-4 or 5+)	N/A			N/A	
21215-0036  und be filed within 72 hours afth Mendal Hygiens marked other than "matural" re event, the Medical Examine To Re Commissed by		0 7. Father's Name (First, Middle, Last)			18.Mother's N	ame (First, Middle, Maid	en Surname)	
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If iten 27 is marked other the injury or other traumatite event, the Med To Re Comment of the co	<u>.  </u>	Zane Spencer	Fake		Jer	nifer Lyr	nn King	
212 ould be d Menta s marke iic even		9a. Informant's Name/Relationship (Ty			ess (Street and Number			
MD and 2 shot lith and m 27 is aumatic		Jennifer L. K	ing /mother	8250 N	orthview I	Road Dunda	alk MD Co. Location - City	21222 or Town, State
e, N I and Health item	12	0a. Method of Disposition  XBurial 2 Cremation 3	T- cr	ace of Disposition (I ematory or other pla	ce)			
nof ages ant of at: If	- 1	Burial 2 Cremation 3  Donation 5 Ather Specify:	Hol	-	y Cemetery			
Baltimore, permit. Pages I an Department of He Important: If ite Injury or other tr	- 12	1. Signature of Fundal Service Licens	see / Joi	22. Name a	and Address of Facility	300 Mace A	Ave. Ba	lto. MD
ii II De B	1	3a, Part I. Enter the disease, or compl	a nokuo	Con	nelly Fund	ral Home	of Ess	Approximate Interval
Physician	1	3a. Part I. Enter the disease, or compl failure. List only one cause on ea	ÇII III IC.	Do not enter the mo	ge or dying, such as care	ido or roop. acc., america		Between Onset and Death
/Medical		mmediate Cause (Final disease a.	Undetermined					
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	اة	Sequentially list conditions, If any, leading to immediate	Due to (or as a consequence of	):				
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of	1.				
asit sd	Examiner	events resulting in death) Last						
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buri be	팋	IF FEMALE:	23c. If yes, outcome of pregr				23d. Date of del	
876 tifical ing ph	텵	3b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de		oregnancy	Month	Day Year
ox 6 ath cer attend	Sici	1 Yes 2 No 9 Unknown	Pregnant at time of deal	ath 5 Other	Specify)			
Records, P.O. Box 68766 The law requires that the death certificate icate has been signed by the attending phypage 2 should be detached for use as the page 2.	Physician/M	Part II. Other significant conditions		esulting in the under	lying cause given in Part			e to the cause of death?
P.O.	ğ					1Yes		Probably 4 Unknown
ds, squire, sen sig	Completed					24a. Was ar autops		re autopsy findings available r to completion of cause of
Orcal law re has be	톍					perform	ned? dea	th? Yes 2 No
Re( The ficate ; page	ဦ	and the modical T			26.Place of Death (			
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i of Vital Records, P.O. B ing Physician: The law requires that the d. After this certificate has been signed by the tuneral director, page 2 should be detached.	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	
nding nding th	ioi	1 Natural 5 Pending	5-19-08	5:45 am	1 Yes 2 X			011
ivisior or Attendafter death Director:	ficat	2 Accident Investigat 3 Suicide 6 X Could no	28e. Place of Injury - At h	ome, farm, street, fa	actory, office building, etc	or Town, St	ate) 1044 .	or Rural Route Number, City Joyoin Court
Division of Vital Records, P.O. Box 6876i ital or Attending Physician: The law requires that the death certificate ans after death ral Director: After this certificate has been signed by the attending phylled in by the funeral director, page 2 should be detached for use as the	Certification:	determine	ed (Specify) single			Ellico	tt City,	Md.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page		To 10 100	cian: To the best of my knowled er:On the basis of examination a	ige, death occurred	at the time, date and pla	ce, and due to the cause curred at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
o the ithin on the omple	Medical		er:On the basis of examination a and manner stated.	and/or investigation,	29c. License number		29d. Date signed	(Month, Day, Year)
H \$ F 8	ž	29b. Signature and title of certifier	11 200		O.C.M.E.		May 20, 200	_
		Mohun Bras	sel MD		U.O.IVI.E.		, = 3	
		30. Nam and address of person who	o completed cause of death (Iter Assistant Medical Exam	m 23a) iner = 111 Per	n Street, Baltimore	e, MD 21201		
			32 Registrar's Signa					
St Reaist	tate trai	14 0 17 27 27 9	008	K And				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Alexander William Kubik, Jr. рм May 18, 7:40 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood <u>Baltimore</u> If Under 1 8. Date of Birth (Month, Day, Year) 08/17/1953 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days Yrs Director 217-64-4460 54 PA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov adical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 168 English Run Curcle 21152 Funeral United States within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Health and Mental Alexander W. Kubik, Sr. Donna Marilyn Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Mrs. Donna M. Kubik (Mother) 168 English Run Circle, Sparks, Maryland 21152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite 1 ☐ Surial 2 ☐ Cremation ö 3 ☐Removal from State Woodlawn Cemetery 05/24/2008 Baltimore, Maryland in ury 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. any 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstrac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown þ Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaced use contribute to the cause of death? þ 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? Yes 2 No 1∐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death Check onl one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner & Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 | Hedical Examiner: On the basis of examination and manner stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 10062638

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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		•	for State Registrar		· · · · · · · · · · · · · · · · · · ·		ertifica					Reg. No.	20	ΠQ	16	003
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath	V.	ear	3. Time of D	Death
	Physicia /Medic		Hsiao-Sing Kam								May 19	, 200	8 '	ear	6:20	A. M
	Examin		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City	, Town, o	r Location	n of Death		4c. (	County of	Death		
ر			Suburban Hospit  5. Social Security Number	:a1 6. Sex	7. Age (In vrs.	last hirthd		esda er 1 Year	T If Unde	er 24 Hrs.	9 Date of Bi		ntgon		ice (State or	Foreign
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	ס		Usual Residence of Decedent						<u></u>			.,				
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g	permit. Pages 1 Department of I Important: If Ite any Injury or ot once.		21. Signature of Funeral Savice	Lensee	M0089	96	Robert 7	A. Pun	iphrey	Fune	ral Home, Beth	Bethes	oda-Ch	evy 0	hase, I	nc.
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	/Medical		disease or condition resulting in death)	a	(or as a conseq	uence of):									- WCCR	
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01	Physician: r this certific ral director,	일	examiner? 1 ☐ Yes 2 ☑ No		Inpatient 2	ER/Outpa	atient 3 🗆 [	OOA Oth	ner: 4 □	Nursing H	ome 5 Res	sidence 6	Other	(Specify	)	
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	ń		30. Name and address person	who completed cau	ise of death (Iter								117			
	J	: 7)	Eric J. Park, 1			eorge	town H	Road,	Bet	hesda	, Mary	land	2081	4		<u>'</u>
	Sta Registr		31. Date filed (Month, Day, Year)	2008	Registrar's Signa	The parties of the pa	frank	B								

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2008 18 <u>Loretta O'Connor Kahl</u> May 4:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/19/1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕶 F Months Days Hours Min 88 Director 219-10-0157 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Inportant: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the "Accidat Eventina" must be notified any once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No MD Baltimore Phoenix 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14120 Sagewood Road U.S.A. 21131 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Department Supervisor Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin O'Connor Ona Holmes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Kahl/Daughter in-law 14120 Sagewood Road, Phoenix, MD 21131 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven Mem Pk 05/22/08 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acheroscleronic **Physician** Cordiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ZNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 烃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, completely filled in by the funeral To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

> 6 State Registrar

29b. Signature and title of c

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Westminister MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 13 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Mede FALLSTON HARFORD OUR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nooths | Days | Hours | Min. | (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1**/**M 2□F 218-03-4596 Director Tune 30, 1919 Westminster, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo +ALLSTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21047 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and 2 should be filed within 72 hours after of ealth and Mental Hygiene. n 27 Is marked other than "natural", or Iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 TYes Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life) DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be ည or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau ittle-Ine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 108 21. Signature of Funeral Service Licensee FOREST HILL, MO 21050 Cremation Services BelAir FUNCRAS Cha 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): P.O. Box 68760% Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autonsy performe 2 No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Tes 2 H မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

9

Registrar

31. Date filed (Month, Day, Year)

23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HIDREN NOWAKOUSKI SS 32 Registrar's Signature

SS PULSORA NE. BELAIR, MP 21014

D08096

20,200 8

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENRY OSCAR LUTSCHE 00:49 A M MAY 2008 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balto Washington Medical Ctr Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F Months Days Hours Min. 219 03 0995 89 1919 Maryland 23 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XNo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7954 Farmingdale Ct. 21122 <u>U.S.A.</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1938 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 1946 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Baltimore City College (1-4or 5+) Battalion Chief <u>Fire Department</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Joseph Lutsche Bertha Frances Goldstraw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Thompson/daughter 7954 Farmingdale Ct. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 5/20/08 Crownsville, MD 22. Name and Address of Facility GJ Gonce Funeral Home, 100 Divisors Dr. Pasadena, MD 21122 21. Signature of Funeral Service Licensee 23a. Part1. Emily the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNI-UMONTA disease or condition resulting in death) DAY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy ths? Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown it conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DESEASE 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

27

Baltimore,

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

MD

**Funeral** 

Director

?7 is marked other than "natural" or Items 23a or 28a-f show traumaric event, the Medical Examiner must be notified at

Department of Heal. Important: If Item 27 any injury or of once. sician and burial-transit

Examine Physician/Medical þ Be 2

ALCOHOLD STREET	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
	Part II. Other significan

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

4 Homicide

Hospital: 1 Inpatient

Date of Injury

(Month, Day Year)

			103
2	24a.	Was	
		auto	psy ormed
4	$\Box$	100	

24a. Was an autopsy	
performed	ľ
1□ Yes 2	

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★No

ce of Dea	ath (Cl	neck only one)	
Nursing H	lome	5 ☐ Residence	6 □Othei
	204	Doggriba haw ini	

ck only one)	
Residence	6 ☐Other (Spec
escribe how ini	ury occurred

AOC	Other: 4	☐ Nursing H	iome	5 ☐ Res	idence	6 [	Other
28c.	Injury at Work? 1 ☐ Yes		28d.	Describe	how inj	ury o	occurred

201.	City or	Town,	State)	umber	oi nuiai	noute	Nun

29a. Certifier
(Check only
one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

SU.	Signature and title of certifier	
	. / / //	
	hounn	-
		MO

5 Pending

investigation

6 Could not be determined

D 60796

26. Pla

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM HAW, Suite 305,

305 DRIVE, GLEN BURNEL HOSPETAL

Registrar

neral Director: / / filled in by the fi

31. Date filed (Month, Day, Year) MAY 23 2008



2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 21, **Physician** Richard James Law, Sr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium 8. Date of Birth 5/23/1936 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 219-32-4599 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "redical Examinat must be notified at Director MD Baltimore Phoenix 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21131 LISA 3 Jackson Manor Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 2 Specify: 3 ★Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie B. Law Velma Clinger ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phoenix, MD 21131 Richard J. Law. Jr. / Son 3 Jackson Manor Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Hilltop Serv. Corp. Towson, Maryland 5/24/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Towson, Maryland 21204 Ruck Towson Funeral Homé, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) the 1 ☐Yes 2 ☐No 9 Unknown P s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? RICHARD Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 st 24a. Was an autopsy The perform 1 ☐ Yes 2 X No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\blacksquare$ Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 X Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

12:45

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

Day

1 ☐Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Year

1 ☐ Yes 2 ☑ No

Pennsylvania

White

Рм

the

TARIQ MAHMOOD 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

MAY 23

29a. Certifier (Check only

> 2300 DULANEY VALLEY RD. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Apour **O**RIGINAL

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 05 2008 06:00a<sup>™</sup> Rita S. LeBorys /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10032 Ichabod Lane Baltimore Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/14/1920 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 👿 F 213-10-3120 88 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at any injury or other traumatte event, the Medical Examiner must be notified as 10b. County 10d. Inside City Limits N/A 1 X Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 6107 Walther Avenue 21206 Funeral 2 should be filed within 72 hours after death in and Mental Hygiene.

is marked other than "natural", or Items 238 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Conrail/Railroad Rate clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pietro Sartori Angela Migliorini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Petri, Niece 10037 Ichabod Lane Baltimore, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 05/20/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. lexandra 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPD 40203 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 10 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: Division the Hospital or Attending 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Klux D 3/291-5/20/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 6701 N Chorus St 21204 Su. te 4202 KlOUSZ 32 Registrar's Signature 31. Date filed (Wonth, Day, Year) MAY 2 3 2008 State Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 **Physician** Malek May 20, 7:10 PMM Abde1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 29, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours Days Egypt 281-90-5199 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 6012 Valerian Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2☐No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify: White Completed by Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dentist Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental Wissa Malek Lydia Salama ..ore, M.
..ermit. Pages 1 and 2 sho.
Department of Health ~
Important; if item /
any injury or
any injury or 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roushdy Malek - Brother Akron, OH 44303 969 Mayfair 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cleveland, Ohio Riverside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 5-24-2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Faulhaber Funeral Home Broadview Hts., OH 7915 Broadview Rd. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Immediate Cause (Final Physician Ventricular Fibrilation disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner B Cell Lymphoma Sequentially list conditions, if any, each of the cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Urinary Tract Infection the death certificate be execu resulting in death) Last Due to (or as a consequence of) Hepatitis C Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Yes 2□No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Obstructive Lung Disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy autopsy performed? Yes 2 4No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) May 21, 2008 lue 3 30. Name and address of person who completed call se of death (Item 23a) (Type, Print) Sima Nourani Zenuz, MD 8600 Old Georgetown Rd. Bethesda, MD 31. Date filed (Month; Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 State	Maryland / Department of Health and M		LUUU IUUTL
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.	3. Time of Death
	Physici		James M. M.	attican	Month Day	
-	/Medic Examin		4a. Facility Name (If not institution, give street and nun	nber) 4b. City, Town, or Location of Death		County of Death
	CX4IIIII	eı	2912 Linganore	Ave Parkville		Baltimore
	Funeral		5. Social Security Number 3 6. Sex	10110110	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		267-73-2425 18M 20F		Aug 31, 196	7 Cuba
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	<i>J</i> .	10d. Inside City Limits
	the Marylan 28a-f show	ō	max Ball			1 ☐ Yes 2 🗹 No
	the 7	rec	10e. Street and Number	Harkuille 10f. Zip Code	10g. Citi	izen of What Country?
	h with	a D	2912 Linganore A	Ne 21234		USA
	should be filed within 72 hours after death with the Maryland not Mental Hygiene.  marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Experience in ust be notified.	Funeral Director	0. 1. 10100.1010	dent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Speces?   If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	after or its		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	2 No	riioari, oto.,	Specify:
ö	hours hural"	sd by	3 ☐ Widowed 4 ☐ Divorced Year or Da		1 465 16	white
5	in 72 r"nal	Be Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	na i	ind of Business/Industry
212	withi	mo.	Elementary/Secondary (0-12) College (1-	Maintenance Spec	4	eality
٦	e filed al Hyg othe vent,	Se C	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden	
Maryland 21215-0036	uld be Menta Irked	To	Roy Mathis	on Kat	hleen	Malone
ar	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura	al Route Number, City o	or Town, State, Zip Code)
	and ealth m 27 her tr		Nance Lee Mattison-	Spouse 2912 Linganore Av	re Parkuil	11e mD 21234
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from S	comptany cromatony or other place)	Date 20c. Lo	ocation - City or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercitive in ust be netified at once.		4 □ Donation 5 □ Other (Specify)	Cremation Services 1727	/2008 Hore	st Hill, mb
Ba	permit. Departi Importa any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Evans Funeral Cha 8800 Harford Roc	ipel & Crem	lation Services
			23a. Part 1. Enter the disease, or complications that ca	aused the death. Do not enter the mode of dying, such as cardiac o		Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	enioscleratic Cardiovas	CI ON DIS	Onset and Death
	/Medical		resulting in death)	or as a consequence of):	174 (0)	
	Zamino	-e	Sequentially list conditions, b.	or as a consequence off.		
P.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	or as a solissique like siy.		
1/2	e exec an an rial-tr		that initiated events c c Due to (or	or as a consequence of):		
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Ψ	as di		IF FEMALE:			
Вох	eath certif attending for use as	ian/	in the past 12 months?	come of pregnancy irth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O.	the de y the ched	by Physician/M	1  Yes 2 No 4 Pregn 9 Unknown 9 Unknown	ant at time of death 5 ☐ Other (specify) wn		
	that ned b	Y P	Part II. Other significant conditions contributing to de	ath but not resulting in the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Division of Vital Records,	quires en sign uld be	q p			1 ☐ Yes 2	□ No 3□ Probably 4□ Unknown
O O	aw rei	Completed			24a. Was an	24b. Were autopsy findings available
Ä	The I	mo;			autopsy performed? 1 ☐ Yes 2 ☑ No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
/ita	clan; ertific ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death		
of \	physic this c		1 ✓ Yes 2 □ No Hospital: 1 □ Ir			6 ☐ Other (Specify)
n C	ding Phys	jo	Taracara Differenting	of Injury h, Day, Year) 28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
isi	l or Attend after death Director: /	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Deposited determined 28e. Place		28f. Location (Street an	nd Number or Rural Route Number,
Ö	al or / s after il Dire	Certification: To	4 Homicide determined buildin	ng, etc. (Specify)	City or Town, State	)
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Examiner: On the ba	best of my knowledge, death occurred at the time, date and place, asis of examination and/or investigation, in my opinion, death occurr	and due to the cause(s	) and manner as stated.
	thin 2 the P	Medical	one) and mann 29b. Signature and title of certifier	er stated.  29c. License number		te signed (Month, Day, Year)
	F>Fŏ		I his the the Mass	No. 7 18117	1	21 2008
		4	30. Name and address of person who completed cause	e of death (Item 23a) (Type, Print)	1,49	12/2000
	10		Philip Militelle	MD GTrimble Hill CT.	Latheruil	le, MD 21093
	Sta		No.	egistrar's-Signature		
	Registr	ar	MAY 2 3 2008	ACTION OF LAND		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death **Physician** MUL 8 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMURE REHABILITATION EXTENDED CARE 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Country), Country), MORE MI 6000 Director 0 10 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE ALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? X604 21239 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 D7 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. White 3 ☐ Widowed 4 ☑ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other this any Injury or other traumatic event, <u>ithe ones</u>. erintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ober Mulvanei ျှ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scovery  $\alpha$ 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location 3 ☐Removal from State Evans Funeral Chapel-Bolfin 18/08 5 ☐ Other (Specify) Forest Hill, MD 4 Donation 21. Signature of Funeral Service Acenses 22. Name and Address of Facility ARPORD PD., BALTIMORE, MD 21234 EVEDS FUNCTOR Charpel+Cremation Services-Parky , or complication, that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each fire. 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to it in a clot-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-trans Division or Vital Records, P.O. Box  $68760^{\prime}_{\prime}$ Due to (or as a consequence of) attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1∐ Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 TYes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated.

941

State Registrar

29b. Signature end title of certifier

CITAN

Day Year)

AURORA

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

LOCH RAVEN

3 Registrar's Signature

39

BOULEVARD

29d. Date signed (Month, Day, Year)

OK PORd State

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

29b. Signature and title of certifier

Ana Rubio MD. 31. Date filed (Month, Day, Year) 29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

May 12, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2. Date of Death 3. Time of Death Elemore Month MORGAN Year /Medical 1625 2003 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University 01 mayland Baltimore **Funeral** 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Yes 8/6/1931 Birthplace (State or Foreign Country) Days Director Hours <u>434-44-8006</u> 76 Usual Residence of Decedent Louisiana permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Vermillion Kaplan 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7004 Tee Robe Rd. 70548 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 12 fes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: White Be Completed 16a. Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Elemore Morgan Dorothy Golden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Morgan, wife P.O. Box 428 Maurice, Louisiana 20a. Method of Disposition

1 Burial 2 Decremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 ☐ Other (Specify) Bayview Crematory 5/19/08 Baltimore, Md. 21. Signature of Funeral pervice Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Ritchie Hgwy. Balto. Md. Part1. Enter the disease, occumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Distrus Syndrome Acute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 23d. Date of delivery the 5 ☐ Other (specify) Month Day Year 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? mital value Primase certificate has been irector, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Reguntation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending investigation 28d. Describe how injury occurred 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 1 SCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 122224 Medical Resident 18 2008 25+1 30. Name and address a person who completed cause of death (Item 23a) (Type, Print) Minghan Leo 22 South Greene Street Battomare, MD 31. Date filed (Month, Day, Year) State 82. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Franklin Delano Newell 06:10 AM May 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 218-26-9687 Yrs. Director Jan. 15 1934 Usual Residence of Decedent 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, In Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1954 North Avenue 21122 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within marked other than Elementary/Secondary (0-12) College (1-4or 5+) Software Developer 12 2 U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be f and 2 should be t Health and Mental Unknown Newell 2 Hazel Hager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. Newell of Health (son) 7832 Elizabeth Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Date Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 2008 Glen Burnie, Maryland 21. Signature of Euneral Service Lib nego 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) O /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): burial-transi 96 and that initiated events resulting in death) Last Due to (or a a consequence of): physician Physician/Medical the signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should been has r 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Ves 2 No certificate 1 ∐Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this After thi funeral ( 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 2-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

The law requires that the death certificate be executed P.0. Division of Vital Records, or Attending Physician: ours after death.

neral Director: Al To the Hospital o within 24 hours aff To the Funeral Di

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5-0036

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Bai

Certification: To Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Highway Glen Burnie, Md, 2106/ 1600 rain Vin 31. Date filed (Month, Day, MAY 2 3 2008 Registrar's Signature

State Registrar

Examir **Funeral** 

**Physici** /Medic

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evantine 2, and by ratified at anones.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	e, Last)				ا ا	<ul> <li>Date of Death Month</li> </ul>	Day	Year	3. Time of Death		
James		Α.	Owens			05		800	2:40a. M		
4a. Facility Name (If not institution	nber)	4b. City, Town, o	Death		4c. Count	y of Death					
Seasons Hosp	oice	_		llsto			Bal	timo			
5. Social Security Number	6. Sex 1 <b>火</b> □ M 2 □ F	7. Age (In yrs. last birthda	Months Days	If Under 24 Hours	4 Hrs. 8 Min.	. Date of Birth (Month, Day,		9. Birthp	olace (State or Foreigi otry)		
212-46-6796	X-M ZUF	61 Yrs				09 14			PA		
Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location						0d. Inside City Limits		
Toa. State									1 X Yes 2 □ No		
MD NA	4	Balti									
10e. Street and Number			10f. Zip Code			10	og. Citizen of	What Cour	ntry?		
2613 East Ol:	iver Stre	eet	212	13				S.A.			
11. Marital Status	12. Was Dece Armed For		<ol><li>Was Decedent of If Yes, specify Cub</li></ol>	lispanic Origi an, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		ce - Americ			
1 Never Married 2 Marr	If Yes, Giv	re 21	1 □ Yes 2√€ No	Specify:			Speci	fv: R1	ack		
3 ☐ Widowed 4 🎇 Divorced	Year or Da	ates:									
15. Deceden (Specify only highe	t's Education st grade completed)	1 (G	ecedent's Usual Occup ive kind of work done	during most of	of working		16b. Kind of E Stell				
Elementary/Secondary (0-12)	College (1-	-4or 5+)	e. DO NOT use retire	d)	_			.a ria	LID		
12th grade	2yrs	Nur	sing Ass				Nursi		ome		
17. Father's Name (First, Middle,						First, Middle, M	aiden Surna	me)			
Clarence Ower	ıs			Mary	7 Ĺ.	Gore					
19a. Informant's Name/Relations	hip (Type. Print)	rathari	ailing Address (Street				-		2121		
Calvern Russe	∍ll Owens	S 25	04 Calve		Hgts	a Ave,	Balt	imor	e, Md		
20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other pla	ce)	Dat	e 2	20c. Location	- City or To	own, State		
1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		state	rematory			2002	Balti	more	ьм.		
21 Signature of Funeral Service			<ol><li>Name and Address</li></ol>	ess of Facility	•	2008	سلبا ستهاسد		,		
MADANIA	(1) Aug	VOLA !	larch F/H	West				N -3	21215		
23a. Part Enter the disease, or	complications that	used the death. Do not	300 Waba	ng. such as c	ardiac or	respiratory arre	ore,	MG	21215 Approximate		
sh. k, or heart failure. List only one cause on each line.											
Imme ate Cause (Final d'se e or condition resulting in death)	a	Metastat	ic Pance	eatic	Car	16er					
resulting in death)	Due to (	or as a consequence of):									
Sequentially list conditions,	b										
if any, leading to immediate cause. Enter Underlying	Due to (	or se a consequence of):									
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с										
resulting in death) Last	Due to (	or as a consequence of):									
	d										
	1						1/				
IF FEMALE: 23b. Was decedent pregnant		come of pregnancy						ate of deliv	ery		
in the past 12 months?			3 ☐ Ectopic pregnand 5 ☐ Other (specify) _				Month Day Y				
1 □Yes 2 □No 9 □ Unknown	9 Unkno										
Part II. Other significant condition	ons contributing to de	eath but not resulting in the	e underlying cause ai	en in Part I.		23e. Did tob	acco use cor	ntribute to t	he cause of death?		
	Ů,	0	, ,				s 2 No	3 ☐ Prol			
						24a. Was ar autopsy	v 1.	prior to co	ppsy findings available impletion of cause of		
						perform	ned?	death? 1 ☐ Yes			
25. Was case referred to medical				26. Place of	of Death (	Check only one		/			
examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 ☐ ER/Outpa	tient 3 DOA Oth	or.	· · · · ·	5 ☐ Reside	. /	ther (Specia	fv) [1====================================		
27. Manner Death	28a. Date of	of Injury 28b. Time	e of 28c. Inju	ry at		d. Describe ho			Mospic		
	9 .	h, Day, Year) Injur	y Wo	ń? ]Yes 2.⊡N	lo						
1 Natural 5 Pendin		of Injury - At home, farm,				f. Location (S+	reet and Nur	ther or Rus	al Route Number,		
2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could		ng, etc. (Specify)	sassi, lastory, onlice		20	City or Town		IDOI OI FIUIC	ar route realines,		
2 ☐ Accident investig	ined 28e. Place	ig, oto: (-p)			1						
2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	nined 286, Place buildir								-4-41		
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only	nined 28e. Place buildir	best of my knowledge, deasis of examination and/o	eath occurred at the t	ime, date and opinion, death	d place, ar	nd due to the ca	ause(s) and rate and place	manner as :	stated. o the cause(s)		
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)	ng Physician: To the Examiner: On the ba	best of my knowledge, do	r investigation, in my	opinion, death	d place, ar h occurred	d at the time, da	ate and place	, and due t	o the cause(s)		
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only	ng Physician: To the Examiner: On the ba	best of my knowledge, do	r investigation, in my	opinion, deatl	h occurred	at the time, da	ate and place	, and due t	o the cause(s)		
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2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	ng Physician: To the Examiner: On the barand mann	best of my knowledge, di asis of examination and/o ner stated.	r investigation, in my	opinion, deatl	h occurred	at the time, da	ate and place	, and due t	o the cause(s)		
2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and time of certifier  30. Name and address of person	ng Physician: To the Examiner: On the band mann	best of my knowledge, di asis of examination and/o ner stated.	29c. Licens D (5)	opinion, deatl	h occurred	at the time, da	ate and place	, and due t	o the cause(s)		

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Primus Rosalind 05 6 2008 5:10p. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2√2 F Months Days Hours Min. 83 N/A 28 Trinidad Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes XXNo Pikesville Baltimore MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21208 Trinidad 15 Rocky Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Lv Armed Forces? 1 ∐Yes 2 🙀 No 1 Never Married 2 Married Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Emily Primus 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pikesville, Md 21208 Montgomery Porter-son 15 Rocky Lane, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 5/22/08 Baltimore, md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signa ure p Funeral Service Licensee 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Imme late Cause (Final Dels sames WILLES distase or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events MIGNE resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Month Year Day contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗀 No Other (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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Director

Funeral

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Completed

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event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" once.

Physician/Medical Examiner

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To the Hospital or Attending Physician:

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the burial-tran for use as detached by cate has been signed I page 2 should be deta Medical Certification: To Be Completed by certificate has director. After this funeral death s after death the filled in by

Part

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown			
II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco use 1 ☐ Yes 2 ☐ I
4 Aunty	ontraclere			24a. Was an autopsy
Durphosia	- I quotasta	oun toe		performed? 1 □ Yes 2 □ Nø
Was case referred to medical examiner?			26. Place of Dea	th (Check only one)
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ [	OOA Other: 4 In Nursing H	lome 5 Residence 6-2
Manner of Death  ∫ Natural 5 □ Pending □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury o
Suicide 6 Could not be	e			

Dyptosio	r a gustanta	71
25. Was case referred to medical examiner?		
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ΕR
27. Manner of Death	28a. Date of Injury	28

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

38

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License numbe WW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) WARDS.

TBAMIRA NO

State

31. Date filed (Month, Day, Year MAY 2 3 3 2008

NO 2. Registrar's Signature

CON

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF 166-30-6602 24. 1938 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Director McLean Virginia Fairfax 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? USA 5919 Frazier Lane 22101 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Baltimore, Maryland 21215-0036 Specify: Specify: White <u>م</u> 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "ns any injury or other traumatic event, the Medic once. College (1-4 or 5+) Elementary/Secondary (0-12) CIAExecutive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Gahagan Robert Boyle ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7412 Conestoga Way, San Diego, California 92120 Glenn P. Phillips/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/24/08 Arlington, Virginia Columbia Gardens 21. Scruture of Funeral Service Licensee 22. Name and Address of Facility 171 W. Maple Ave MOO968 Money & King Funeral Home, Vienna, Va.22180 Moune Theth Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Multingan Failure **Physician** hours /Medical resulting in death) Due to (or as a cui sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last entopenia The law requires that the death certificate be executed burial-trar gned by the attending physician be detached for use as the buris Box 68760, Physician/Medical entenna IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown Completed s certificate has been siç director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 200 No 4 🗆 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Tes မ After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of eath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 5 To the Hospital within 24 hours a To the Funeral C completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahi Thabuna 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robinson 2008 Zora 20 2:00 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1603 Odell Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2√2 F Months Days Hours Min. 65 Antigua 165-66**-**9063 28 42 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 XYes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21237 U.S.A. 1603 Odell Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2√2 No If Yes, Give Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Public Schools Registered Nurse 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Falcona Thomas Walter A. Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 Kent Robinson-Husband 1603 Odell Ave, Baltimore, Md 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel 6/2/08 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West al 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Avenue Balto, MD 21215 Approximate Interval Between Onset and Death Wering Carcinoma Immediate Cause (Final Metastalic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

10a. State

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Director

Funeral

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**Examiner** 

**Funeral** 

Director

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within 72 hours after

2 should be filed v n and Mental Hygie is marked other t

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Department of He
Important: If item
any Injury or othe

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran signed by the peen has page 2 certificate director,

the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

Hospital or Attending

After thi funeral of death.

Exami Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Z No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier completely (Check only one) within 2.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print)
201-109 Back River Meck Road Balhmore Mayland 2/12 Sabapalhi

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 3 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Augustine Rzegocki 12:45Å 19. May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co.

9. Birthplace (State or Foreign Country) Timonium 1 Year | If Under 24 Hrs. | Stella Maris Hospice 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 215-18-0839 86 Director June 9,1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show disal Evolution 5 ust be notified at Maryland Baltimore Dundalk 1 ☐ Yes 2\\ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States Funeral 1940 Searles Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼No Specify. \$ Specify: 3 √Widowed 4 ☐ Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Pistore ဥ Joseph Quattrocche 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1940 Searles Road Dundalk, Maryland 21222 (Daughter) Eleanor Kraska 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 5/21/2008 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause that underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 1 □ Yes 2 No 2 🗆 No ospital or Attending Physician: I hours after death. uneral Director: After this certifica ly filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 X Other (Specify) HOSPICE Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19h 2008

death with the Maryland

Maryland 21215-0036

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Pages

MAY 23 31. Date filed (Month, Day, State Registrar

ERNESTINE WRIGHT

2300 DULANEY VALLEY RD.

and address of person who completed cause of death (I)em 23a) (Type, Print)

May

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a PtI,25,27,280 rtifipate we 18379,05/22/08dhb Heg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** 21.55 MARY ELIZABETH may /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNION MEMORIAL HUSPITAL BALTIMONE BALTIMOTELEIT 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗗 F Months Days 130 16 1290 MEDISOLIANS NEW YORU Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Nes 2 No RALTIMORY Directo BALTIMOTEL LITY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number DAUL STRUET 91718 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLARICAL US LOURS NIMES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental is marked ELIZABETH SCHAUB SOMERS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any Injury or other trau 4734-38TH WEST, SLATTUE WA RITA RANGE 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State HANOVIR, MD പ്പാരവ 4 ☐ Donation 5 ☐ Other (Specify) YSBITAMESS TURBSIA 22. Name and Address of Facility Signature of Juneral Servide Licensee 21076 ARDENZ COM ATION 2237 CONNEMES AS MONORMY MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ersis **Physician** disease or condition resulting in death) /Medical Ulcer Decubitus Examiner Sequentially list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner requires that the death certificate be executed tracture and the burial-trar Due to (or as a consequence of): physician Malnutrition Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No page 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 X Yes <del>212 No</del> 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Man or of Death 28d. Describe how injury occurred -tural 5 Pending investigation 1 ☐ Yes 2 📉 No Unknown Unknown M 2 Accident Multiple falls death. hours after death uneral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Unknown Unknown within 24 hours a To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438546-1413 may 12, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Union Memorial Hospital sherrard maurice MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

22

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Dorothea Ruth Schultz 3:35 P.™ 2008 /Medical 05 19 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium, MD Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🗓 F Director 79 2<u>18-26-4999</u> 06-17-1928 Baltimore, MD Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: I flem 2 Ts marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examine mealt be notified at Director MD Baltimore 721 Beaverbrook Road, Baltimore, MD 21212 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 721 Beaverbrook Road, Baltimore, MD 21212 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 📉 No ≥ If Yes, Give Year or Dates: Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Utilities Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Ashline Mary Spink 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Schultz, Son 721 Beaverbrook Road, Baltimore, MD 20a. Method of Disposition permit. Pages 1 Department of H 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ⋈ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Cemetery 5-23-08 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Heo Mitchell-Wiedefeld Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to Cir as a our section of the ng physician and as the burial-tran Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 **X** Other (Specify) Certification: To HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 43725 5/21/08

State Registrar

Maryland 21215-0036

altimore,

Vital Records, P.O. Box 68760,

ō

DOROTHEA SCHULTZ

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DR. TARIQ MAHMOOD

MAY 23

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, State of Maryland / Department of Health and Mental Hygiene tems 25,27,28a-f per me 88/9 05/22/08dhb

Reg. No. Amend Items Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year seraldine 07:25 AM Mac 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Bayview Medical Center Baltimore
If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2**/**F 215-22-2715 Usual Residence of Decedent Baltimore, MD Director 1428 20 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director M 1 ☐ Yes 2 No BACTIMORE DALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 USA 21234 HVENUR 12. Was Decedent Ever in U.S. Armed Forces?, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BANKino ident 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 1ewic onie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 TIMORE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Important: If any Injury or ometry BALTIMORE M.D 21. Signature of Funeral Service Licensee and Address of BALTIMORE, MD 21239 Evans Funera Cho remation Services - Parkville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each give.

Immediate Cause (Institute of the disease or condition resulting in death)

a. Distriction of the condition of the cause of the Approximate Interval Between Onset and Death & days **Physician** /Medical Due to (or as a consequence of): Examiner Fails (Mulhple CERTIFICATION APPROVED BY MEDICAL EXAMINER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Encephalopathy
Due to (or as a consequence of) Box 68760, Physician/Medical 6110 blasting Multitor me IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
1 XYes 25. 26. Place of Death (Check only one) 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Unknown Unknown<sup>M</sup> 1 Tyes 2**X** No Multiple Falls 2 XAccident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number of Rural Route Number, City or Town, State) 7708 Bagley Ave. Parkville, MD determined Home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD coelgus, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Dr. Vinay Pare 31. Date filed (Month, Day, Year) MAY 2 2 2008

Fastern

4940

2. Registrar's Signa

Avenue Baltimore,

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #2,perMD,g879 5/23/08 TT Certificate of Death Reg. No. 2. Date of Death Month 127 1. Decedent's Name (First, Middle, Last) 2008. Day **Physician** 151e 96 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFOLD ucen. astle 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Min. Year) Months Days 216-38-3139 1 □ M 2 1 F Hours Director 16 1941 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** stree Has 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced hit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Horner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Smith-Soad 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location 1 Burial 2 □ Cremation 3 Removal from State rlington 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FORESTHILL, MD Evans Funeral Chapel+ CREMATION SERVICES rola 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cancer 5months Metastatic ana /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 100 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 Ves 3 Probably 4 Unknown 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed To the Funeral Director: After this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death. completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) leasailain M.D D45530 -20-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SIUASAILAM 602, S. ALWOOD, sulte 200, Belair MD 32. Registrar's Signature MAY 23 31. Date filed (Month,

State

Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** A M May 14, 0045 Isarah Emmanuel Sewell /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Howard Howard County General Hospital Columbia If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year) Days Months Hours 1/14/192 213-12-6757 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any flury or other traumatic even and flury or other traumatic even any flury or other traumatic even any flury or other traumatic even any flury or other traumatic even any flury or other traumatic even any flury or other traumatic even any flury or other traumatic even any flury or other even any flury or other traumatic even any flury or other traumatic even any flury or other even and flury even any flury or other even and flury even any flury even 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Funeral Director MDHoward Jessup 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 20794 8306 Barkwood Court 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married Specify: African 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced *American* 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools Foreman Repair Shop 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Romana Pascaul George Sewell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8306 Barkwood Court, Jessup, MD 20794 Ethelind Sewell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/19/2008 MD National Cemetery Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Fone P.A of Balto. CO. 9200 Liberty Road Randallstown, MD 21133 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** ASPINATION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART DISEAS ATHERO SCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed INSUFFICIENCY resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy altrel to milelian 2 1 No 1 ☐ Yes 2,5 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 🗌 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053150 NAY 14 200 \$

DHMH 17 Rev 1/2001

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Registrar

9650 Lenhape Re Suite 110 Columbie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

Sione MO

32. Registrar's Signature

		•	for State Registrar Amend #9, pe	State of Ma rINf, G881	ryland / 7/9/0	Depa 8Cel	artment of F tificate of i	lealth and N <i>Death</i>	Mental Hy	giene Reg. No	ZUU8	16857
	Physicia	an	1. Decedent's Name (First, Middle, La		Stewa				2. Date of De	ath Da	v Year	3. Time of Death
	/Medic Examin	al	Daisy M  4a. Facility Name (If not institution, give	e street and number)	Drewe	11.	4b. City, Town, o	r Location of Death	April	-	. County of Deat	6:15 A M
	LAGIIIII	č. ∂* ~	Gladys Spellman Nursing Home Cheverly							ince Ge		
1.	Funeral Director		5/9-34-90/9	ex 7. Age	94	irthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da June 5	th ly, Year ,191	9. Bird	hplace (State or Foreign buntry) S.C.
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
	a-f eh	ctor	Maryland Prince	George's	Mitch	ellv	7111e					1 X Yes 2 □ No
	ith the	Director	10e. Street and Number 3800 Aynor Drive				10f. Zip Code <b>2072</b>	1		_	tizen of What Co	
	death with the Maryland rms 23a or 28a-f ehow r must be mutified at	Funeral	11. Marital Status	12. Was Decedent B	ever in U.S.	13.	Was Decedent of H		pecify Yes or No	-	ited Sta 14. Race - Ame	ncan Indian,
220	urs after o	by	t ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		ll Yes, specify Cuba 1 □ Yes 2 🙀 No	Specify:	Rican, etc.)		Specify: B	e, etc. L <b>ack</b>
3-003e	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16	(Give	dent's Usual Occup	during most of wor	kıng	16b. K	Kind of Business	/Industry
7	within ene. than	ідшо	Elementary/Secondary (0-12) <b>Twe1th</b>	Coilege (1-4or 5			DO NOT use retired sekeeper	d)		Pr	ivate	
7 0	Hygir other	Be Co	17. Father's Name (First, Middle, Last,			nous	ekeepei	18. Mother's Nam	ne (First, Middle			
yland	ould be Menta arked artic ev	To B	Jim McCardell					Unknov				
Mar	and 2 sho alth and 27 is mu er traumu		19a. Informant's Name/Relationship ( Horace V. Stewar				ng Address (Street <b>) Aynor D</b>					
more,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show entry or other traumatic event, the Madical Exerciper must be intillised at ODCs.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		cemet	ery, crei ny 1	esition (Name of matory or other place femorial	Cem 2008		Lane	ocation - City or dover Ma	ryland
Baltimor	permit. Departminentalimportal		21. Signature of Funeral Service Lice	1580			2. Name and Addre					
F.	w		23a. Part1. Enter the disease, or com shock, or heart lailure. List only	plications that caused one cause on each lin	the death. Do	not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	irrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):						
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8/60,	icate be executed physician and the burial-transit	ai E	l.	Due to (or as	a consequence	B 01).						
200		ledlcai		d								
C. Box	at the death certific by the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		Ectopic pregnancy Other (specify)	У			23d. Date of de Month	livery Day Year
1	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death be	ut not resulting	in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
cords,	w requires been sign should be	ed by							1 🗆	Yes 2	2 <b>≛</b> No 3 □ P	robably 4 Unknown
Ä	و څو	Completed							24a. Was auto perf 1 \subseteq Yes	psy ormed?	prior to death?	utopsy lindings available completion of cause of
VII	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			0,4	26. Place of Dea	th (Check only	on <i>e)</i>		
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0	Attending Fir deeth. sector: After by the funer	atior	1 Statural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Day	Year)	Injury		rk?  Yes 2∐No			,	
DIVISION	- E E	Certification:	3 Suicide 6 Could not be determined			larm, st	reet, factory, office		281. Location City or To	(Street a wn, Stai	and Number or F te)	lural Route Number,
	To the Hospital of within 24 hours af You the Funeral D completely filled in	Medical C		nysician: To the best of miner: On the basis of and manner sta	examination a							
	To the within 2 To the complet	Me	29b. Signature and title ol certifier	Δ Λ			29c. Licens				ate signed (Mon	
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4	•		30. Name and address of person who <b>Tahminak Ahmed M</b>	completed cause of department of D 3001 Hos	eath (Item 23a <b>pital</b> ]	)(Type. <b>Driv</b>	e, Cheve	rly, Mary	1and 20	785		
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			For State Registrar		Maryland / D	ера		lealth a	and M	ental Hyg	_	08	16858
	Physici	an i	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month		Year	3. Time of Death
	Physici /Medi		Harold Scott				1			May	12	2008	5:17 P <sup>M</sup>
*	Examir	er	4a. Facility Name (If not institution, Washington Adv	-	iber)		4b. City, Town, o		of Death			ty of Death	
	Function				7. Age (In yrs. last birth	hdav)	Takoma If Under 1 Year	Park If Under	24 Hrs.	8. Date of Birth (Month, Day		gomery 9. Birthp	lace (State or Foreign
*	Funeral Director		203-30-9083 Usual Residence of Decedent	1 M 2□F		rs.	Months Days	Hours	Min.	(Month, Day March ]	0,1939	Penn	sylvania
	nyland		10a. State 10b. County		10c. City, Town							1	0d. Inside City Limits
	8a-f	cto	Maryland Prince	George's	Temp1e	Hi							1√Nes 2 No
	th with th	Funeral Director	10e. Street and Number 3061 Brinkley Ro	oad T-1			10f. Zip Code 20748				United		•
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fune	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For	<sup>2</sup> □Nº 1957-		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Or an, Mexica Specify:		ecify Yes or No- Rican, etc.)	BI	ace - Americ ack, White, ify: Blac	etc.
9	72 hou	Completed by	15. Decedent's (Specify only highest	Education	16a. I	Dece	dent's Usual Occup	ation	t of works	20	16b. Kind of	Business/In	dustry
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2	led wi	Co	Twe1ve	Four	An	aly	yst			45	Nation		ard
and	be fill had be fill had out	Be	17. Father's Name (First, Middle, L. Norman Scott	ast)			And an artist and a second and		er's Name I Whi	(First, Middle,	Maiden Suma	ame)	
Z	hould d Mei mark	ဥ	19a. Informant's Name/Relationshi	n (Type Print)	19h	Maili	ng Address (Street				r City or Tow	n State Zin	Code)
Ma	th an		Sarah Scott/Wife				Brinkley						
ē,	s 1 ar f Hea item other		20a. Method of Disposition		20b. Place of		esition (Name of matory or other place		May		20c. Location		
Ę	Page ient o nt: if ry or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Dopation 5 ☐ Other (Spe		Idle		National	,	2008		Friangl	le. VA	
Baltimore, Maryland 21215-0036	permit. Departm Imports eny inju		21. Signature of Funeral Service Li	INT.		16	61 Good 1	hope	Rd S	ert G. M E, Wash	Mason I Ington	Tunera	1 Home Inc
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	e be executed /sician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence of								
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isi	death death ctor: y the	ficat	2 Accident investiga 3 Suicide 6 Could no	t be	of Injury - At home, fari	m, str		163 2		28f. Location (S	treet and Nun	nber or Rura	al Route Number,
Ο̈́	at or after after 1 Dire	Certification:	4 Homicide	buildin	g, etc. (Specify)					City or Tow			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely illed in by the funeral director, page 2	Medical	29a. Certifier 1 Cartifying (Check only one) 2 Madical Ex	Physician: To the la kaminer: On the ba and mann	pest of my knowledge, sis of examination and er stated.	deatl Vor in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, alh occurr	and due to the c ed at the time, c	ause(s) and r fale and place	manner as s e, and due to	tated. the cause(s)
	To the within To the Comp	Me	29b. Signature and little of certifier	qu	Hit		29c. Licens	e number	2-1	ż	29d. Date sign	ned (Month,	Dey, Year)
0	27		30. Name and address of person w	no completed cause	of death (Item 23a) (1	Гуре,	Print)	1	111	Spri	19	54	· 5# 214
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 3	2008	gistrar's Signature	So	enter	•		,	7		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY 20, Year **Physician** 10:25AM SMITH SOL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 3031 FALLSTAFF RD., APT. 507 BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Funeral 1 M 2 □ F Months Days Hours Min 057-26-4022 80 Director 11/3/1927 LITHUANIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director Yes 2□No N/A MD BALTIMORE 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3031 FALLSTAFF RD., APT. 507 21209 USA 23a Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 🏻 Married WHITE Baltimore, Maryland 21215-0036 ō 1 □Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWNER ELECTRICAL CONTRACTING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MICHAEL SMITH ROCHEL. 2 SHULMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. MANYA SMITH / WIFE 3031 FALLSTAFF RD., APT. 507 BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of Pages 1 20c. Location - City or Town, State ARLINGTON -1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 5/22/2008 4 ☐ Donation 5 ☐ Other (Specify) AMUNO CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 SOL LEVINSON & BROS 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending properties IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) P.0. the a ☐Yes 2 ☐No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by sign 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an N autopsy page performe After this certificate 1 ☐Yes 2 ZNO 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 5 ☐ Pending investigation death. 1 ☐ Yes 2 🗌 No 2 Accident s after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

completely

(Check only one)

29b. Signature and title

31. Date filed (Month, Day,

of certifier

30. Name and address of person who completed cause of

Year.

2008

23

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Registrar

and manner stated

32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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	or 24	ä	10e. Street and Number			10f. Zip (
	th wi		148 Prince George	Street		2140
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shany Injury or other traumatic event, the Medical Evanter must be notified once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent   Armed Forces?   1 K Yes 2 1 f Yes, Give Year or Dates:		13. Was Decede If Yes, speci
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/land	should be file and Mental H is marked oth aumatic eveni	To Be	17. Father's Name (First, Middle, Last, George J. Schladt	)		
Mary	d 2 shollth and I	'	19a. informant's Name/Relationship (William H. Schlad			Mailing Address
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or other y corium, I
Balti	permit. I Departm Importal any Inju		21. Signature of Funeral Service Licer		M01346	22. Name and Rockvil Rockvil
Division of Vital Records, P.O. Box 68760,	hours after death.  The law requires that the death certificate be executed to be considered to the continuous after death.  The law requires that the law requires that the death certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit.	leted by Physician/Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of Hypertension	a. Dementi Due to (or as b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	a consequence of a consequence of pregnancy 2 Fetal death time of death	of):  of):  3
Division of Vital Re	<b>spital or Attending Physician:</b> The law requires that the de hours after death.  Ineral Director. After this certificate has been signed by the y filled in by the funeral director, page 2 should be detached	al Certification: To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Ph		ry 28b. T y, Year) 28b. T Iry - At home, far c. (Specify)	rm, street, factory,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death George J. Schladt, Jr. May 19, 2008 3:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Summerville at Woodward Estate Bowie 8. Date of Birth (Month, Day, May 15, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours Min. 1921 New Jersey 87 135-14-3536 Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 □ No Code 10g. Citizen of What Country? 01 United States ent of Hispanic Origin? (Specify Yes or No-ify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White X No Specify Occupation 16b. Kind of Business/Industry k done during most of working e retired) Federal Government 18. Mother's Name (First, Middle, Maiden Surname) Nelly Murphy (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Street, Annapolis, MD 21401 e of her place) Date 20c. Location - City or Town, State May 22, 2008 nc. Bethesda, MD Address of Facility Robert A. Pumphrey Funeral Home/ le, Inc. 300 West Montgomery Avenue le, MD 20850 le, le, Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, 23d. Date of delivery egnancy Month Year ecify) 23e. Did tobacco use contribute to the cause of death? use given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐Yes 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Bc. Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) office at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24768 May 19, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Dabbs, M.D. 277 Peninsula Farm Rd., Arnold, MD 21012 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 23 Part 180

State

Registrar

Physician

/Medical

Examiner

**Funeral** 

Director

No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Helen Vergenta STIIS 8:55 AM 05 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ve of Maryland Medecal Center Baltemore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 XF Director 220-03-0012
Usual Residence of Decedent Jul. 1920 Maryland 87 filed within 72 hours after death with the Maryland Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 XNo Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive, Apt. 341 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify: 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry the M-dical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory worker U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any linjuy or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edna Louise Cullem Daniel (UNK) Harman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 521 Main Street, Delta, Pennsylvania, 17314 Connie Klein / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Episcopal 5/23/2008 Abingdon, Maryland 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland, 21009 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. art1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final Physician Pulmonary edema disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, any, leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit The law requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₩ No been signed by the should be detached 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ + MCA distribution stroke 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed 1∐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2₩No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI P 21178

Registrar
DHMH 17 Rev 1/2001

State

Jose

31. Date filed (Month, Day, Year)

22 S. Greene St. Baltmore, MB 2120

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C. Cabassa

2

MB

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:25<sup>Р м</sup> Louise R. Smith 2008 Mav 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 ₽ F Months Days Hours Min. 88 217-36-3677 Director 03-20-1920 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD Baltimore Director Ruxton 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1407 Maywood Avenue 21204 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examinal must any Injury or other traumatic event, the Medical Examinal must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry H. Keller Ethel M. Garrish ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Smith/Daughter 1407 Maywood Ave., Ruxton, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prospect Hill Cemetery 5-24-2008 Towson, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 1050 York Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMINIA disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner STROKE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Directo (or as a consequence of) I Records, P.O. Box 68760, The law requires that the death certificate be executed burial-transit CORONARY DISEASE Due to (or as a consequence of) physician Physician/Medical the as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been funeral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? ospitat or Attending Physician: The hours after death.

Lineral Director: After this certificate by filled in by the funeral director, pag Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) #OSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 MAY 21,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 DANIEUE OBBETMAN, MO 6505 N CHARLES ST, SUITE 209 BALTIMORE, MO 2,204 31. Date filed (Month, Day, Year) 82. Registrar's Signature State MAY 2 3 2008 Registrar

Certificate of Death

**Physician** Examiner

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant

9 ☐ Unknown

in the past 12 months?

25. Was case referred to medical examiner?

1 ☐ Yes

27. Manner of Death

2 ☐ Accident

3□ Suicide

4 ☐ Homicide

1 Natural

IF FEMALE:

Completed by

Be

2

Certification:

this certificate

After

after death.

within 24 hours a To the Funeral L

To the Hospital or Attending Physician:

23c. If yes, outcome pf pregnancy

Live birth 2 Fetal death 3 Ectopic pregnancy 4□Pregnant at time of death 5 Other (specify)

2 ☐ ER/Outpatient

23d. Date of delivery Month Day

htributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28a Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) 1 TYes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

thin Bue BA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier

3□ DOA

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6530 Michael alte

2008

31. Date filed (Month, Day,

5 Pending investigation

6 ☐ Could not be

egistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Elizabeth Taylor 2:45 P. M 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Hospice If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 23, 1918 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 → F Months Days Hours Virginia 89 214-14-4931 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f show 1 ☐ Yes 2 No Maryland Baltimore County Timonium Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinational being once. United States 21093 8 Talbott Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Horne Tandy A. Dix 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Mary G. Suffecool (Daughter) 3 Washington Street Timonium, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 24, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Timonium,Maryland 21. Signature of Funeral Service Licensee Page 10 1 dde fernatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 tur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause or each line. or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** of weeks Nene /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown rephropathy 24b. Were autopsy findings available prior to completion of cause of death? cate has b autopsy perform 2 □No 1 □Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 | Nursing Home 5 | Residence 6 Nother (Specify) 1 ☐ Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

State

6701 N.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES

Y 2

Charles ST TRVXW NO Z1204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-1 per me 8879,05/22/08dhb

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Physician 2008 1023 PM **CAROLE** M. VINCENT 31 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Tel i th 1 hirwird 1 C howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yei JAN 7, 1941 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 3√X F NY 061.32.5833 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner roust be notified at 1 ☐ Yes 2 ☐ No Director **COCKEYSVILLE** BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 10103 DAVENTRY DRIVE 21030 USA Funeral items 12. Was Decedent Ever in U.S. Armed Forces & 1 \_\_Yes 2 \_\_No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0, 21215-0036 1 ☐ Yes 2XXNo Specify ģ Specify: 3 ☐ Widowed 4 Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE\_CLERK ADVERTISING Department of Health and Mental Hygiv Important: If item 27 is marked other any Injury or other traumatic event, It once. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi ပ္ HENRY CARDAMONE ELSIE ROMANO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 DUBLIN DRIVE LUTHERVILLE, MD 21090 BROTHER ROBERT CARDAMONE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 🖎 remation 3 ☐ Removal from State 5.1.2008 BAYVIEW CREMATORY INC BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE, MD 21061 GREGORY FINK M01148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or , or heart failure. Lie shoo Immediate Suse (Final **Physician** CHADKIC 0 disease or condition resulting in death) /Medical GRAN Due to (or as a consequence of) Examiner 111 Vica CERTIFICATION APPROVED BY MEDICAL EXAMINE a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are this is death), or the cause of the caus Examiner be executed sician and burial-trans dica resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical the death certificate the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy ō in the past 12 months? Month Day 5 Other (specify) ed by the a 1 ☐Yes 2 ☐ No. Ö 9 Unknown σ. s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 2 No 1 □Yes 2 No Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1**X** Yes 2₩No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation **H**atural 04/28/2008 2 Accident 6:00a. M r death. 1 Tyes 2 No Subject fell down stairs. the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10103 Daventry Dr. Cockeysville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

DHMH 17 Rev 1/2001

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MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GENUIT 32. Registrar Signatur

HOMAS

2008 2

31. Date filed (Month, Day, Year)

P11-1700 a

SINAI HOSPITAL OF BALTIMORE

2000

**Physician** /Medical **Examiner** The law requires that the death certificate be executed and the burial-tra Division or Vital Records, P.O. Box 68760. attending physician as

the

cate has been signed by t , page 2 should be detach

this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

filled in by the

Medical

31. Date filed (Month, Day, Year) DR SaviTha

MAY

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

۵

MD

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after death with the Maryland

and 2 should be filed within ealth and Mental Hygiene. n and Mental Hygiene.

permit. Pages 1 and 2
Department of Health a
Important: If Item 27 Is
any injury or other trat
once. Pages 1 and 2 truent of Health 2

Maryland 21215-0036

Baltimore,

MOF

4

5

Examiner Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Coronar

25. Was case referred to medical			26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	]ER/Outpatient 3□ [	DOA Other: 4 Nursing F	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
				e, and due to the cause(s) and manner as stated.

(Check only one)			vestigation, in my opinion, death occurred at the til	
29b. Signature and	title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
	Xh	- MD	D52379	5-23-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRanklin Square DR 9000 Shivananda Balto Md 21237 32. Redistrar's Signature orar's Sign

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of Health and M Registrar Amend Item 21 per fh, g879, 05/22/08dhb	ientai Hy	/gier Reg. N	1e 10. 20 (	08	16867			
	Physici		1. Decedent's Name (First, Middle, Last)  Antonia Walker	2. Date of D Month May 7		Day Y	'ear	3. Time of Death			
Mary.	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	пау /		c. County of	Death	11:58 p. <sup>™</sup>			
-1			Montgomery General Hospital Derwood			Mont	gom	ery			
	Funeral		Months Days Hours Min I	8. Date of B	irth av, Yea	. 9	. Birth	place (State or Foreign			
	Director		Usual Residence of Decedent	11/28/	1910	6	<b>NJ</b>				
	rland ow		10a. State 10b. County 10c. City, Town or Location				1	10d. Inside City Limits			
	Mary I-f sh	tor	MD Montgomery Silver Spring					1 □Yes 2√2 No			
	or 282	irec	10e. Street and Number 10f. Zip Code		10g. (	Citizen of Wh	at Cou	ntry?			
	th wit	<b>Funeral Director</b>	15107 Interlachen Drive #104 20906		1	USA					
	r dea	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spell Fyes, specify Cuban, Mexican, Puerto F	ecify Yes or N Rican, etc.)	0-	14. Race - Black,		can Indian,			
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The strip and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show represents the modified at other traumatic event, the Medical Exeminal mast be notified at	oy F	1  Never Married 2  Married			Specify:		White			
21215-0036	2 hour	Completed by	15. Decedent's Education 16a, Decedent's Usual Occupation		16b.	Kind of Busi	ness/In	idustry			
215	hin 7. e. man "n	ple	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	ost of working							
7	filed wit Hygien Ither th	Con	4 Homemaker		(	Own Ho	<b>ne</b>				
ng	be file	Be		r's Name (First, Middle, Maiden Surname)							
<u> </u>	should be f and Mental s marked of umatic eve	ို		Osalie Giaimo  Bural Boute Number City or Town State Zin Code)							
Za	d 2 sho th and ?7 Is πε traums		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural  19b. Mailing Address (Street and Number or Rural								
ē,	: 1 and F Health tem 27 other to			ate		Location - Ci					
Baltimore, Maryland	Pages nent of int: If its iry or o		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Chesapeake Crematory 05/12	2/2008			•				
量	+ <b>5 5 5</b> -				!			tion Svcs.			
Ö	permi Depar Impor any ir		Stephen D. Lohrmann per dvr 933 Gist Ave., Silve								
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory	arrest,	-		Approximate Interval Between			
40	hysician		Immediate Cause (Final disease or condition — a Acute Cardiac Arrest					Onset and Death			
_	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					la .			
		r do	Sequentially list conditions. If any, leading to immediate  b				_	nours			
	ansit A de	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)  C. Acute Mycardial Infartion	`				hams			
,	exec an and ial-tra	Exa	resulting in death) Last  C. The transfer events resulting in death) Last  Due to (or as a consequence of):	<u>.                                    </u>			+	10010			
09/89	inicate be executed g physician and as the burial-transit	edical	Atheroscleratic Cardiovascu	lar D	ise	95e		year			
	E 50, es	-	IF FEMALE:				$\perp$	/			
SO .	death cerr e attendin d for use a	sician/N	23b. Was decedent pregnant in the past 12 months?			23d. Date o		,			
	the a	/sici	1   Yes 2   No 4   Pregnant at time of death 5   Other (specify)   9   Unknown			Month	1	Day Year			
J	e law requires that the or has been signed by the le 2 should be detached	Phys	Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I.	23e Did	tobacco	n use contribu	ite to t	he cause of death?			
ds,	sign d be	d b	Atrial Fibrillation, Pacer					bably 4 Unknown			
ဂွ	shoul	ete	Hx Preumonia	24a. Was		O.4h Wo		anno findina a socilable			
9 1	rne raw cate has b page 2 s	Completed	TIX TICOMONIA	auto	psy ormed2	prio	re auto or to co tth?	opsy findings available impletion of cause of			
	certificate rector, pag	O	25. Was case referred to medical 26. Place of Death		2 N	No 1 □	]Yes	2 No			
	this certific	OB O	examiner?  1 Yes 2 Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home			6 □Other	(Specia	f <sub>V</sub> )			
0 L	fter th	ı.		8d. Describe			Орсол	<i>y</i> /			
o i	eath.	catic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No								
Division	fter d fter d Sirect in by	Certification: To	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location ( City or To	Street a	and Number	or Rura	al Route Number,			
<u></u>	ours a		29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place a	and diversity		(a) and the					
2	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ed at the time	date a	(s) and manr ind place, and	d due to	stated. o the cause(s)			
F CF	with:	Ĭ	29b. Signature and title of certifier Med Acrets 29c. License number			Date signed (/					
			29b. Signature and title of certifier  Med Asack 29c. License number  Dept EN  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		5	1201	-				
	25		30. Napre and address of person who completed cause of death (Item 23a) (Type, Print)  Wichael Kerr MD 18101 Prints Philip D-	2083	5						
	Stat	е	0.000		*						
	Registra	ır	MAY 2 3 2008								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ZIMMERMAN 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE KEHABILITATION EXTO MUKE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** 1☐M 2☐F Days Hours 212-48-0323 60 7-5-1947 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the warywar. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medica Examiner must be notified at 1 ☐ Yes 2 X No MD HARFORD BEL AIR Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 710 EASTWOOD COURT Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 9 6 9 – 7 5 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE <u></u> 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FOOD & NUTRITION VA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental in it it it it is marked o JOSEPH Ε. ZIMMERMAN CATHERINE (BROWN) ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 OLD MOUNTAIN RD NORTH JOPPA, MD JOHN F. ZIMMERMAN, JR/SON 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State METRO CREMATORY CATONSVILLE, MD 5-26-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 211 CHESACO AVENUE ROSEDALE, MD 21237 21. Signature of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Examiner by Physician/Medical as the for use Completed

Division or Vital Records, P.O. Box 68760,公 the Hospital or Attending Physician:

Sequentially list conditions,	b. // ////		1	-100	100	101	- 10 X	11000			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):									
that initiated events resulting in death) Last	cDue to (or as a conseq	juence of):									
•	d										
IF FEMALE:	23c. If yes, outcome pf pregna	ancv					23d. Date of del	P			
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 ⊟Ectopic p					Month Day Year				
Part II. Other significant conditions of	art II. <b>Other significant conditions</b> contributing to death but not resulting in the underlying cause given in Part I.  23e. Dic  AI COHOL DEPENDENCE										
ALCOHOL	1 🗆 Y	es 2 No 3 X Probably 4 Unknown									
	24a. Was autop		24b. Were au	utopsy findings completion of c	available						
						rmed?	death?	2 No	2000		
25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	ne)					
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3□ D	OOA	Other: 4 Nursing H	ome 5 Resid	lence	6 □Other (Spe	cify)			
27. Manner of Death  1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M		njury at Work? 1 □ Yes 2 □ No	28d. Describe h	now Injur	ry occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	28f. Location (S City or Tox	Street an In, State	nd Number or Ri	ural Route Nun	nber,					
29a. Certifier 1  Certifying Ph (Check only one) 2 Medical Exam	ysiclan: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at th	ne time, date and place my opinion, death occu	e, and due to the urred et the time,	cause(s date and	) and manner as d place, and due	stated. e to the cause(	s)		
29b. Signature and title of certifier	Heshmi		9c. Lic	ense number		29d. Da	te signed (Moni	h, Day, Year)			
Shen A	05	-22-	2008	3							
30 Name and address of person who	completed cause of death (Iter	n 23a) (Type, Print)									

State Registrar

Be

Certification: To

Medical

31. Date filed (Month, Day, Year)

within 2

3900 LOCH RAVEN BLUD BALTIMORE MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 03:20 A<sup>M</sup> Esther Anderson 0.5 04 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 17 51 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday, Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 1 X F 56 466-90-3558 Director Mississippi Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1X Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2001 Georgian Woods Place #22 Funeral 20902 death v 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Account Specialist 12 Fannie Mae 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental H Grady Terry ပ Ann Quinn Terry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Kenyatta Terry-Allen/Daughter 8161 Fenwick Ct. Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 5/9/08 Laurel, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Marshall's Funeral Home MO1491 4217 9th St. N.W. Washington, D.C. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fonly one cause on each line. 234 Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Inon UN /Medical Due to (or as a consequence of): Examiner Immal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): The law requires that the death certificate be executed ellinor n Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ne Hospital or Attendin 24 hours after death.

The Funeral Director: A pletely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the within 2. and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue, Takoma Park Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State MAY 0 9 2008 Registrar

		1 - For State Registrar amend #7&8	State of Per FH	f Marylan <b>G880 6,</b>	d / Depa <b>/04/<u>08</u>/</b>	artment of F	lealth a <i>Death</i>	and Mer	ntal Hygi Re	ene g. No. 20	08	16870
Physic	ian	1. Decedent's Name (First, Middle, Las							Date of Death Month	Day	Year	3. Time of Death
/Med		Sarah Amarte						Ma	ay	6 200		11:39 A M
Exam	iner	4a. Facility Name (If not institution, give				4b. City, Town, o				4c. County		
Funera		Shady Grove Advent  5. Social Security Number 6. S		7. Age (In vrs.	last birthday)	KOCI If Under 1 Year	cv1lle		Date of Birth	1933	tgom 9. Birth	ery place (State or Foreign
Funera Director			□M 2 <b>X</b> F	84	74 Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day, ay 29,	1923	Gha	ntry)
D		Usual Residence of Decedent		140 00								
arylar show	-	10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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with a or	Ö	21011 Sojourn Cou	ırt			10f. Zip Code 208	376		10	Unite		ŕ
Jeath TIS 23	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. \	Was Decedent of H		gin? (Specify	Yes or No-	14. Rac	e - Ameri	can Indian,
after or iter		1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Giv	2 X No		f Yes, specify Cub I □ Yes 2█ No	an, Mexican Specify:	, Puerto Rica	an, etc.)		k, White, T	etc. Black
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withir ene.	F	Elementary/Secondary (0-12)	College (1	-4or 5+)		Homemaker				Or	m Ho	m <i>e</i>
Hygi Hygi other ent, t		17. Father's Name (First, Middle, Last)			<u> </u>			r's Name (Fi	rst, Middle, M			
Id be denta rked tic ev	To Be	Nii Amarteifio					Naa	Ahia				
Lar y rail of Z IZ I J-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (1			19b. Mailin	g Address (Street	and Numbe	er or Rural Ro	oute Number,	City or Town,	State, Zij	o Code)
and and and and and and and and and and		Elizabeth Pettus/	Daugnte		1	Sojourn						
Pages 1 and nent of Health int: If item 27 iny or other to		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	State 20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date Mav 10	-	0c. Location -	City or T	own, State
t. Partmen	4	4 ☐ Donation 5 ☐ Other (Specify	)	AL		Cemeter		May 10 2008	§ G	ermant	own,	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any hijary or other traumatic event, the Medical Examiner must be notified at any lone.		21. Signature of Euneral Service Licen	2			Name and Addre			0 East	Deer 20877	Park	Drive,
		23a. Part1. Enter the disease, or comp shock, or hear failure. List only	olications that ca	aused the death ach line.								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Hy	moxic E	inconha	lopathy						Onset and Death 7 Days
/Medical Examiner		resulting in death)	Due to (	or as a consequ	uence of:							
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uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									83	
exec an and rial-tra		resulting in death) Last	Due to (	or as a consequ	uence of):						-	
icate be executed physician and sthe burial-transit	dical		d									
ertifica ing ph	(1)	IF FEMALE:										
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Fetai	ideath 3□	Ectopic pregnancy	y				te of deliv	ery Day Year
at the de by the a	ysic	1 ☐ Yes 2 🚻 No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of do wn	eath 5∟	Other (specify) _						24,
that the by		Part II. Other significant conditions of	ontributing to de	eath but not resu	ulting in the ur	nderlying cause giv	en in Part I.	1	23e. Did toba	acco use cont	ribute to t	he cause of death?
uires la sign	d by								1 🗌 Yes	s 2 No	3 Pro	bably 4 XUnknown
law require as been sig 2 should b	Completed							_ h	24a. Was an	24b.	Were auto	opsy findings available
The la	E O		-						autopsy perform	ed?	prior to co death? 1 □ Yes	mpletion of cause of
	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Ci	1□ Yes 2 heck only one		I La res	2 110
Physician: The la	P.	1 Yes 2 No	Hospital: 1K	npatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nur	rsing Home	5 ☐ Resider	nce 6 □Oth	er (Speci	fy)
	ü	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury	Wor			Describe how	v injury occur	red	
ttend death stor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1	of injune. At ho	me form etr		Yes 2□N	_	1 1' (01			10 11 1
after after Direction by	Certification:	4 ☐ Homicide determined	buildir	ng, etc. (Specify	()	eet, factory, office		201,	City or Town,		er or Hur	al Route Number,
spita hours neral / fillec		29a. Certifier 1 X Certifying Ph	ysician: To the	best of my know	wledge, death	occurred at the tir	me, date and	d place, and	due to the ca	use(s) and ma	anner as s	stated.
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examone)	niner: On the ba and mann	asis of examinat	tion and/or in	vestigation, in my o	opinion, deat	th occurred a	at the time, da	te and place,	and due	to the cause(s)
To ti withi To ti	Ž	29b. Signature and title of certifier				29c. Licens	e number	C. 1		d. Date signe		
1		19		2		ME	>- >	85	77/0	>5-	06	-08
		30. Name and address of person who of Shahryar Davari,					rive	Rocks				
91	31. Date filed (Months Dev. Year) 32. Buistrar's Signature											
Regist		MAY 0'9 2	008	ben .	B A	carles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U C Registrar Amend Item 23a per dr., g879, 05/30/08dhl 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:20 P M Ralph Edward Armour, Sr. 2008 /Medical May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 315 Biddle Street Chesapeake City Under 1 Year | If Under 24 Hrs. Cec<sub>i</sub>1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min 1 X M 2 □ F Director 220-12-6816 81 15, 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show at r 28a-f sh notified 1X Yes 2 □ No Director Maryland Ceci1 Chesapeake City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö pe i 23a 315 Biddle Street the Medical Examiner must United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No , or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW Two 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>م</u> Specify. Specify: White 3 X Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bus Driver Transportation marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Charles Walter Armour, Sr. Georgana Harrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neal J. Armour/son 101 Amberwood Drive, Bear, DE 19701 20b. Place of Disposition (Name of cemetery, crematory or other place R.T. Foard Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05-13-2008 Rising Sun, MD 4 □ Donation 5 □ Other (Specify) 21. Signature Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Congestive Heart disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a our sequence of) Examiner Due to (or as a consequence of) burialphysician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ erebrovascular diseuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has page 2 s autopsy performed? Yes 2 No Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending Division 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0053675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Monteleone, MD III W. High St. Suite 214, Elkton MD 21921 6+IVA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY Registra

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H rtificate of L	ealth and N Death		gieneZ ( Reg. No.	008	16872			
	Physici /Medi Examir	cal	4a. Facility Name (If not institution, give	street and number)	ALLGAI	4b. City, Town, or			04 20	Year OO & y of Death	3. Time of Death			
	Funeral Director		5. Social Security Number 195–28–9223  Usual Residence of Decedent	x 7. Age	(In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 1	y, Year)	Cou	place (State or Foreign ntry) nsylvania			
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	rector	10a. State 10b. County Anne Anne 10c. Street and Number		10c. City, Town or Lo Severna				10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 📉 No			
	death with	<b>Funeral Director</b>	245 Berrywood Dri	12. Was Decedent Ev	ver in U.S. 13.	21146 Was Decedent of His If Yes, specify Cubar		pecify Yes or No	USA	ce - Ameri	can Indian,			
0036	hours after tural", or ite al Examine	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 🕅 No	Specify:	Hican, etc.)	Speci		nite			
Maryland 21215-0036	d within 72 giene. er than "nai , the Medic	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	College (1-4or 5+	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) OCTATE Exe	uring most of worl	king	Allied					
yland	nould be file Mental Hy narked oth natic event	To Be (	17. Father's Name (First, Middle, Last) Robert Ashton					Allgaie	r					
re, Maı	BAITIMOYE, IMATYIAND 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Ty Helen L. Allgaier/ 20a. Method of Disposition	nd Number or Rui Drive S		Park, M	D 211	46						
altimo	Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or other		20a. Method of Disposition    Date   Date   Constitution   Date   Constitution   Date   Constitution   Date   Constitution   C											
			23a Part Enier the disease or complessiock, or heart failure. List only or Immediate use (Final	ne cause on each line	ne death. Do not en	er the mode of dying	, such as cardiac	or respiratory a	rna Par	k, MI	Approximate Interval Between Onset and Death			
	Physician /Medical Examiner		disease or condition resulting in death)  a. HYPERCARSIC RESPIRATION   TAILONE    Due to (or as a consequence of):  REURRENT EXUDATIVE PLEURAL EFRUSION											
8760,	ecuted and -transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	END S	consequence of):  TAGE RI consequence of):	FNAL DI	sease							
O. Box 6	The law requires that the death certificate has been signed by the attending plate as should be detached for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	]Ectopic pregnancy ] Other (specify)				ate of deliv	ery Day Year			
ords, P	w requires that been signed I should be det	Completed by P	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did to			he cause of death?			
Vital Records,											opsy findings available impletion of cause of 2 ☐ No			
	sicial certi recto	25. Was case referred to medical examiner?  1  Yes 2 No   26. Place of Death (Check only one)  1  Yes 2 No   Other: 4 Nursing Home 5 Residence												
ion or	al dii	ation: To	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o	28c. Injury Work	4 ☐ Nursing Ho	ome 5 Residence Residence Possible Poss			(fy)			
DIVISION	e Hospital or Attend 124 hours after death e Funeral Director: /	Certification:	3 Suicide 4 Homicide 6 Could not be determined	building, etc.	(Specify)	, farm, street, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)								
	To the Hosp within 24 hou To the Fune completely fi	Medical	29a. Certifier (Check only one)  1. ☐ Certifying Phys 2 ☐ Medical Examin  29b. Signature and the of certifier	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	vledge, death occurred at the time, date and place, and due to on and/or investigation, in my opinion, death occurred at the tire				te to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)				
ì	F.35.8	_	) & m	b. med	ical resid	ent RE	75 <i>0</i> 01		VAY 4					

State

Registrar

31. Date filed (Month, Day, Year) MAY 0 8 200\$

EMMANUEL GORDSPE, MD JOHNS HOPKINS BAYVIEW MED CTR. 4940 EASTERN AVE, BALTIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary 8, 2008 Day Year **Physician** 22:15 P. M James N. Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clintan Southern Maryland Hospital Center 5. Social Security Number 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Challe of Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. March 21, 1927 245-22-03/4 81 Yrs Director North Carolina Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Fort Washington Maryland Prince George's 1- Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 U.S.A. 7606 Klovstad Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces 213, 1945 If Yes, Gillen v. 13, 1046 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married if Yes, Girally 13, 1946 Black 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify. ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Self-Employed Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Jeff Shipp Georgia Brown 19a. Informant's Name/Relationship (Type. Print)
Ms. Sandra E. Taylor—Jones (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7606 Klovstad Drive Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory, Inc. May 17, 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rollins Fureral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final Inturken **Physician** Moute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence off Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events the death certificate be executed the burial-transit attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the at d be detached for 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an performed' After this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of D0055120

Registrar

State

1328 Southern avenue SE Suite 310 Washington De

30. Name and addressypf person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

- MD

Palmer

2 3 2008

Richard

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_		1 - For State Registrar	State of Ma	rylan		artmer rtifica			and M		Reg. No.	200	8	16874
A 1	Physici	an	Decedent's Name (First, Middle, La	_		Rvs	<i>r</i> ant				2. Date of De Month	Day	Ye	ar	3. Time of Death 3:40A. M
3	/Medic	al	Joann 4a. Facility Name (If not institution, gire	Purvey		DLY		Town or	Location of	of Death	May 12,	2008	County of D	eath	
	Examin	er	2312 Ewing Avenue Uni				40. Oily	Suitl	_	Dou.		Pr	ince Ge	orge	's
	uneral irector		5. Social Security Number 6.		(In yrs	ast birthday, Yrs.	) If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir July 27,	th 1954	9. Wa	Birthpla Shiii (	ce (State or Foreign
e Maryland	Milled at	etor	Usual Residence of Decedent  10a. State Marryland  10b. County Prince Ge	orge's	10c. City	y, Town or L Suit	Land								d. Inside City Limits  Y Yes 2 □ No
with th	3a or 2	al Dire	10e. Street and Number 2312 Ewing Avenue	Unit 3			10f. Zi	p Code	2074	6		-	S.A.	Countr	y?
<b>d 21215-0036</b> filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		S. 13.	Was Dece If Yes, spe 1 \( \text{Yes} \)	cify Cuba	ispanic Ori n, Mexicar Specify:	gin? (Sp. n, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - A Black, V Specify:		c.
ZTZTS-0036 od within 72 hours aff giene.	Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		+)	16a. Dece (Give life.	dent's Usi kind of w DO NOT	ork done	during mos	t of work	ing		nd of Busine isekeepi		stry
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Maryland of 2 should be file th and Mental Hy	arked oth atic even	To Be	17. Father's Name (First, Middle, Las Harry J. P	irvey						Fula	e (First, Middle B. M. Bold	len			
Aar 2 sh	reum me		19a. Informant's Name/Relationship								al Route Numbi				
e, E	em 27 thar t		Jamica A. Taylor (Da 20a, Method of Disposition	ighter)	20b. P	2312 lace of Disp	Ewing osition (Na	A HIII	Unit	3.91	tland, N	hryla 21c. Lo	cation - City	or Tow	n, State
Baltimore, permit. Pages 1 a Department of Hes	t: if it		1 ⊠Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Special		0	emetery, cre	ematory or	other plac	(6)		ay 19, 20				
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n ga	any i		met C. In	de							shington		and the same of the same		
Ite be executed	physicien and edical miner transit sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, learning to immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Cirrh</u> Due to (or as a	osis ( a consequence of the cons	Liver I		e.							nterval Between Onset and Death
.O. BOX 68 the death certifica	ed by the attending phys detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Feta	Ideath 3	□Ectopic   □ Other (s						23d. Date of Month		y Day Year
dS, P	50		Part II. Other significant conditions	contributing to death bu	it not res	ulting in the	underlying	cause giv	en in Part I						cause of death?
The law requires that the	cate has been si , page 2 should I	Completed	r				22 11				24a. Was auto perfo 1  Yes	psy ormed?	prior	to com	sy findings available pletion of cause of
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VISION OT VITA Attending Physician: r death.	ar this eral di	7: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injur	y	ER/Outpatie	-	OA 28c. Injur Wor	4 [ ] 140	ursing Ho	me 5 ☑ Resi 28d. Describe			Specify)	
	r: Afte	ation	Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day on	Year)	Injury	м		k? Yes 2 ☐	No					
UIVISION tel or Attending s efter death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not determined		iry - At ho	ome, farm, si	treet, facto	ry, office			28f. Location ( City or To			r Rural	Route Number,
United Hospitel or hin 24 hours efter	he Funer pletely fill	edlcai	29a. Certifier 157 Certifying P 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examina	wledge, dea tion and/or i	th occurre	d at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s date and	and manne d place, and	or as sta	ited. the cause(s)
To the	Com	Z	29b. Signature and title of certifier	Luc X			2	D4647			l		te signed (A 6, 2008		Pay, Year)
	5		30. Name and address of person wh	completed cause of de	eath (Iten	n 23a) (Type	, Print)								
	~		Suresh A. Patel, MD	7501 Surratt	s Ros	d Clint	on, M	rylar	d 207	35					
**	Sta Registi		31. Date filed (Month, Day, Year) MAY 23 200	32. Registra	ir's Signa	ture	وخعي								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> **Physician** Month Pauline Lorraine Barrow May 2008 1635 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rising Sun

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

April 10, 1927 Calvert Manor Healthcare Center Ceci1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 222-16-9519 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 🙀 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? p o "natural", or items 23a 126 Vista Drive 21921 Funeral United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: Completed by 3 X Widowed 4 ☐ Divorced White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene.
27 Is marked other than "
r traumatic event, the Mec Public School Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Service System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley R. Spence Sarah Kite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Patricia A. Logan/Daughter 567 Warburton Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 19 Brookview Cemetery 2008 Rising Sun, MD 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular Accident **Physician** Cerebrul /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Lepression 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.

V

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M.D. 101 COLOUIAC Way Pising Sun, mas

29c. License number

D0028324

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

		State of Maryland						-					
		For State Of Maryland /		tificate of		Mental F	Reg. No.	nna	0 1/07/				
VEG 1		Decedent's Name (First, Middle, Last)				2. Date of I		444	3. Time of Death				
Physicia /Medic		Anne M. Backof				Month Mav	17	2008					
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat			County of De					
*		Union Hospital		E1kton				Ceci1					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month,	Day, Year)	9. E	Birthplace (State or Foreign Country)				
Director		214-36-9744 70  Usual Residence of Decedent	113.			OCT 2	8, 19	37   M	aryland				
yland now at		10a. State 10b. County 10c. City, T	own or Lo	cation					10d. Inside City Limits				
e Mar	ctor	Maryland Cecil Elk	ton						1 X Yes 2 □ No				
ith th	Director	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What	Country?				
leath with the Marylar ns 23a or 28a-f show must be notifled at	eral	150 East Main Street, Apartment		21921			1	nited S					
item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	specify Yes or I to Rican, etc.)	No-	Black, W	merican Indian, hite, etc.				
urs af	þ	1 Married 2 Married 1	1	☐ Yes 21 No	Specify:			Specify:	White				
72 ho	Completed	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Deced	lent's Usual Occup	ation	rking	16b. Ki	nd of Busine					
ithin Jan "Le	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. E	OO NOT use retired	i) i)	ikiig							
filed within 72 hours after death with the Maryland Hygiene. kther than "natural", or items 23a or 23a-f show ant, the Medical Examiner must be notified at	ပ္ပ	12 17. Father's Name (First, Middle, Last)	Ho	memaker	19 Mother's No.	me (First, Middle, Maiden Surname)							
to be feed of	Be	Edward T. Backof				rinski							
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mooce.	ှ		r Town. State	te. Zip Code)									
and 2 alth a 27 Is		Anne M. Backof/Self 150 E. Main St., Apt. 402, Elkton, MD											
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permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee	Hi Hi	Name and Address Cks Home 3 W. Sto	ss of Facility for Fun	erals.	P.A.	-					
0.0 ≥ m 0		Donal S. Hicko	10	3 W. Sto	ckton St	., Elkt	on, M	ID 219					
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siciar certif irecto	Be	25. Was case referred to medical examiner?  1 □ Yes 2 No  Hospital: 1 I Inpatient 2 □ EB/	· · · · · · · · · · · · · · · · · · ·	Othe	26. Place of Dea								
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nding th. r: Affe e fune	ğ	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 □ No			,					
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check ply one)  1 Certifying Physician: To the best of my knowled to the basis of my knowled and manner stated and manner stated.	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to thurred at the tim	e cause(s) e, date and	and manner place, and c	as stated. lue to the cause(s)				
ithin 2 o the	Med	and manner stated.  29b. Signature and the of pertified.		29c. License	number		29d Dat	e signed (Mo	onth, Day, Year)				
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ا ر	-	30. Name and address of person was completed cause of death (Item 23)	a) (Tvpe. F	Print)	1))			1	200				
り		John R. Mulvey, M.D., 111 W. High	St.	. Suite 3	309. E1ki	ton, MD	219	21					
Stat	е	31. Date filed (Month, Day, Year) MAY 2 3 2008  32. Registrar's Signature	1	A. A. B.									
Registra		MINI NO ZOOO JUNEAU JA	PSPOR										
MH 17 Rev 1/200	ונ												

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 May 10 4:12 P M Ernest Lee Burnett, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 305 N. Jonathan Street Washington Hagerstown 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Months Days Hours 212-24-7098 77 04/06/1931 MDUsual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Washington Hagerstown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 N. Jonathan Street 21740 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ĀVes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12College (1-4or 5+) Maintenance Community Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Allen Burnett, Jr. Elizabeth Marguerite Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lesley A. Smith / Niece 301 Kingswood Terrace, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2008 Rose Hill Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 70 Sequentially list conditions, if any, leading to immediate cause. For Unadams Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

attending physician

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica

Division or Vital Records, P.O. Box 68760,

Physician

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

Examine burial-trar Physician/Medical 9 Completed Be Certification: To neral Director;

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation Injury 6 Could not be determined

Other: 4 Nursing Home ome 5€ Residence 6 ☐Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who comp

29d. Date signed (Month. Dav. Year)

31. Date filed (Month, Day, Year)

2 No

1 Tyes

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

MAY 13

State Registrar

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Medic

			1 - For State Registrar	State of M	laryland		artment of F			ental Hy		2000	1607		
ľ	*		Decedent's Name (First, Midd	fle, Last)						2. Date of De	Reg. No.	UUO	3. Time of Death		
ŀ	Physici /Medi		ELIZABETH BEAV	ER BENNETT						4PVIL	23	2008	1640 N		
	Examir		4a. Facility Name (If not institution		)		4b. City, Town, o					County of Death	1		
			Memo	rial Hos	pito	L	EA	STO	No			TAL	pot		
	Funeral Director		5. Social Security Number 217–28–3240	6. Sex 7. A	ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours		B. Date of Bio (Month, Da 9/10/	ay, Year)	9. Birth Cou	pplace (State or Foreig intry) TX		
	and		Usual Residence of Decedent  10a. State 10b. County	у	10c. City,	Town or Lo	ocation		•••			T	10d. Inside City Limits		
	death with the Maryland ms 23a or 28a-f show r must be notified at	Ö	MD KEN	Г	CH	ESTER	TOWN						1 ☐ Yes 2 ☐ No		
	the r 28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	untry?		
	h with		7800 QUAKER N	ECK RD.			216	20			US	SA			
^	be filed within 72 hours after death with the Marylan tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Decedent Armed Forces' rried 1 ☐ Yes 2X	?	13.	Was Decedent of H If Yes, specify Cub	lispanic C an, Mexic	origin? (Spec an, Puerto R	ify Yes or No ican, etc.)	)- 1	4. Race - Amer Black, White			
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and	be fill be fill be ed	Be	17. Father's Name (First, Middle	•					,			den Surname)			
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<u>a</u>	ロモビサ		WILLIAM F. BEN		n		QUAKER 1				, ,	, ,	,,		
ה ה	s 1 and 2 should f Health and Mer ttem 27 is marke other traumatic		20a. Method of Disposition	•	20b. Pla	ace of Dispo	sition (Name of	i	Da Da			ation - City or T			
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	ted nsit	ie e	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	s a conseque	erice oi).									
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	To the Hospital or Attending Physician: White 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C		ing Physician: To the best I Examiner: On the basis of and manner s	of examination										
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7.	^)		30. Name and address of person	1 who completed cause of	death (Item 2	23a) (Type,		V U Z				1-0/			
20	0)		^	clueson MD	82		EAL DR	Sulta	30)	Easto	n, M	2160	)(		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	of Maryland		rtment of H		and Ment		ene	08	16879
	Physici /Medic		Decedent's Name (First, Middle, Last)     Mabel W. Byrd						ate of Death lonth	_	Year 008	3. Time of Death 10:05 P M
	Examir	ner	4a. Facility Name (If not institution, give street and r Genesis Eldercare Spa Cr	reek Cente		4b. City, Town, or	Annap	colis			Anne	Arundel
	Funeral Director		5. Social Security Number 149–18–6157 6. Sex 1 □ M 2 ☑ F  Usual Residence of Decedent	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. D. (A. Ja:	ate of Birth Nonth, Day, n. 14	Year) 1924	Cour	place (State or Foreign htry) Ginia
	Maryland -f show	tor	10a. State 10b. County Anne Arundel	10c. City, T	own or Lo		wood				1	0d. Inside City Limits 1 ☐ Yes 2XXXII
	h with the 23a or 28a at be not	<b>Funeral Director</b>	10e. Street and Number 4742 Flanders Lane TRL	C		10f. Zip Code	20776	_	10	g. Citizen of W	/hat Cour	itry?
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Madeal Examination is stabled at once.	by Funer	Armed	s 2 <b>∑</b> No ∃ive	1	Vas Decedent of Hi Yes, specify Cubar □Yes ঽৢৢৢৢ	spanic Orig n, Mexican, Specify:	jin? (Specify Y Puerto Rican	es or No- , etc.)		k, White,	ean Indian, etc. ack
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Mary	nd 2 should alth and Me 27 is mark r traumati	오	19a. Informant's Name/Relationship (Type. Print) Diane Walker/daughter	1		g Address (Street a Flanders	nd Number	r or Rural Rou	te Number,			Code) Land 20776
altimore,	Pages 1 ar		20a. Method of Disposition  1 ☐ Burial 2XXCremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of patern place)  Cremato:		Date 5/7/200	2	Oc. Location - 0	City or To	
Dall	permit. Departm Importa any Inju		21. Signature of Funeral Serv, e Licenses	ill.	22	Name and Addres	s of Facility	John N	1. Tay	lor Fur	nera]	Home MD 21401
	Cicate be executed Medical Examiner buysician and sthe purial-transit	l Examiner	Sequentially list conditions b. Due to cause. Enter Underlying Cause (Disease or injury that initiated events c.	each line.	ce of):	or the mode of dying	1			nt or b	7	Approximate Interval Between Onset and Death
.O. DOX 00/0	Physician: The law requires that the death certificate the thing continue of the certificate that been signed by the attending physical director, page 2 should be detached for use as the b	Physician/Medical	in the past 12 months?	utcome of pregnancy birth 2 ☐ Fetal dei gnant at time of deatt known	ath 3 🗌	Ectopic pregnancy Other (specify)	37.7			23d. Date Mon		ory Day Year
Las, L	quires that en signed t uld be dett	by	Part II. Other significant conditions contributing to	death but not resulting	g in the un	derlying cause give	n in Part I.	2	3e. Did toba 1 □ Yes	<b>L</b>		e cause of death? ably 4 ☐ Unknown
מים ומ	ilcian: The law requir certificate has been s ector, page 2 should	Completed						_	4a. Was an autopsy performe □Yes 2	ng l	rior to cor eath?	osy findings available npletion of cause of 2 No
	Physician: this certific al director,	To Be		Inpatient 2 ER/		3 □ DOA Othe	r: 4 Nurs		Residen	ce 6 □Othe		1)
_	To the Hospital or Attending is within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral properties.	Certification:	1 Natural 5 Pending (Mo. 2 Accident investigation	e of Injury nth, Day, Year)  e of Injury - At home, ding, etc. (Specify)	b. Time of Injury , farm, stre		at es 2 □ No	o 28f. Lo	cation (Stre	injury occurre		l Route Number,
5	ospital or hours afte uneral Dir ily filled in		29a. Certifier 1 Certifying Physician: To th	e best of my knowled	dge, death	occurred at the tim	e, date and	place, and du	ty or Town, ue to the cau	use(s) and mar	nner as s	tated.
	To the rawithin 24 To the Figure Formplete	Medical	Z Interior Examination of the	nner stated.	and/or inv	29c. License	number		290	d. Date signed	(Month, i	Day, Year)
,	100/1		30. Name and address of gerson who completed cau	use of death (Item 23	a) (Type, P	rigt) D 3'	213	6		5/6/	200	18
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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- I Zxa		4a. F	acility Name (if not institution	, give str	eet and nu	ımber)		4b	. City, Tow		cation of	Death		1	County of Charles	Deam			
			Civista Medical Center						La Plata				(B	1 7		a Birth	nnlace	State or Foreign	
Funeral		5. S	ocial Security Number	6. Sex		7. Age (In y	rs. last birt	nday)	If Under	Year Days	If Under Hours	A Airo				Cou	inuy)		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici				g Physic	ian: To th	e best of my	knowledge	, death oc	curred at t	he time,	date and	place, a	nd due to the	e cause , date a	(s) and ma nd place, a	nner as nd due	stated.	:ause(s)	
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			10 less	00	100_	)				0.0	C.M.E.				way 10	,			_
		}	30. Name and address of pe	rson who	complete	d cause of de	eath (Item 2	23a)			4:	MD	1201						
18	6	- [	Laron Locke MD.	Assis	stant Me	edical Exa	miner	111 Pe	enn Stre	et, Bal	umore,	, IVID 2	1201						_
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Re	gist	rar	MAY 2	3 20	UO ,	SE MELAR	J AS	- Aller											
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland / Department of Maryland	rtificate of Death		g. No. 200	8   688				
7	Physicia	1	1. Decedent's Name (First, Middle, Last)  GLENN IGNATIUS C	OOL	2. Date of Death May	<sup>D</sup> 7, 2008	3. Time of Death 4:00 P M				
	/Medic Examin	2 44	4a. Facility Name (If not institution, give street and number) Golden LivingCenter	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. The security Number 7. The security Number 7. Age (In yrs. last birthday) 7. The security Number 7. Age (In yrs. last birthday) 8. Sex 7. Age (In yrs. last birthday) 9. Sex 7. Age (In yrs. last birthday) 9. Sex 7. Age (In yrs. last birthday) 9. Sex 7. Age (In yrs. last birthday) 9. Sex 9. Se	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth July 31	Year 1928 Per	place (State or Foreign intry) insylvania				
	Maryland -f show fled at	tor	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Lo           Maryland         > Frederick         Thurmon				10d. Inside City Limits 1 ☐ Yes 2 No				
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 5249 G Wigville Road	10f. Zip Code 21788	10	og. Citizen of What Country? U.S.A.					
980	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show int, the Medikal Examiner must be notified at	by Funer	1 □ Never Married 2 ★ Married 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Korea	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:		Specify: White					
215-0	thin 72 h	Completed by	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation  kind of work done during most of work  DO NOT use retired)		6b. Kind of Business/I	•				
Baltimore, Maryland 21215-0036	d be filed wi ental Hygier ed other th event, the	Be	11 17. Father's Name (First, Middle, Last) William Cool	Laborer  18. Mother's Name Mary . Ri	e (First, Middle, M ley	Constructude (Constructude)	etion				
Mary	permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	ing Address (Street and Number or Rur G Wigville Road,			(ip Code)				
more,			20a. Method of Disposition  1 Removal from State  20b. Place of Disposition cemetery, cred	osition (Name of ematory or other place)  lge Cemetery 5/10		oc. Location - City or					
Balt	permit, Departr Imports any Inji		Where H Thalley 1/ 61	22. Name and Address of Facility DBERT E. DAILEY & L5 EAST MAIN STREE	T. THURMO	ONTMD_21					
Physician /Medical  23a. Part. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Physician /Medical  23a. Part. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Physician /Medical  23a. Part. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Physician /Medical  Disease or conditions  Due to (or as a consequence of):											
68760,	ficate be executed physician and stree burial-transit	edical Examiner	b. FAILURE  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	OF THRIVE							
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or Vital Records,	e law has b	Completed			24a. Was al autops perforr 1∐ Yes	y prior to	utopsy findings available completion of cause of				
Vita	Physician: The this certificate ral director, pag	To Be C	25. Was case referred to medical examiner?  1  Yes 2 No	Other:	ith <i>(Check only on</i> ome 5 ☐ Reside	e) ence 6 □Other (Spe	ecify)				
Division or	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral or	Certification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident 1 Could not be determined 28e. Place of injury. At home, farm, si	Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred	ural Route Number,				
Div	oltal or A		4 Homicide building, etc. (Specify)		City or Town		e etated				
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or i	investigation, in my opinion, death occu	irred at the time, d	late and place, and du	e to the cause(s)				
	•	2	29b. Signature and little of certifier	D 00 4795		5 - 09 -	2008				
	3		29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)  5 - 09 - 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SIBTE A. KAZMI, MD 814 TOU House Ave. FREDERICK. MD 21701  31. Date filed (Month, Day, Year)  MAY 0 9 2008  MAY 0 9 2008								
	St Regist	ate trar	31. Date filed (Month, Day, Year)  MAY 0 9 2008  32. Registrar's Signature	Joseph							
		0004	III O C COTT		<del></del>						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:00 PM WILLIAM S. CATHERWOOD 8 2008 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT BARROLL DRIVE CHESTERTOWN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 067 16 251 JAN 21,1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** KENT CHESTERTOWN MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A BARROLL 206 DRIVE 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER MANFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SUZETTE THOMY WILLIAM CATHERWUDD ၉ 5 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CATHERWEOD BARLUCL DRIVE CHESTER TOWN ition (Name of Date 20c. Location - Cit MD 21620 VIZGINIA 206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAFEAKE CREMATOR, 5/10/08 CHESTER MD 22. Name and Address of Fullity MARVIN V. WILLIAMS, TR. FYPETH DICETTS 2/620 205 GLEEN HEREN WM. CHESTERTOWN MD Approximate Approx 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Emr-hole Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner MO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Fisease or injury that initiated events resulting in death) Last Examiner burial-transit and Box 68760. the attending physician Physician/Medical the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown 9 Unknown sate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes No 24a. Was an certificate has I performed 1□ Yes 2□No Hospital or Attending Physician: 25. Was case referred edical examiner? funeral director, 26. Place of Death (Check only one) Be 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Nesidence 6 | Other (Specify) Hospital 2 No 1 Tes Certification: To After this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 2

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day,

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Physician / Medical Examiner 4a. Facility Name (If not institution, give street and number) Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Neg. No. 2. Date of Death Month Day Year 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.

Division or Vital Records, P.O. Box 68760,

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	5. Social Security N	lumber	6. Se	x ]M 2 □ <b>X</b> F	7. Age (In y	rs. last b		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Yea	r)	9. Birt	hplace (State or Foreign ountry)	
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2	3 ☐ Widowed			If Yes, Gi	ve		1 [	JYes 2⊞No	Specify:				Specify:	· WI	HITE	
Completed by Funeral Director		15. Decede	-			164	Decede	nt's Usual Occu	nation			16h	Kind of Bu	sinosel	Industry	
et	(Spec	cify only high	est grad	e completed)			(Give kii	nd of work done  NOT use retire	durina mos	t of workii	ng	100.	Killa of Ba	Silicaar	madatry	
Ē	Elementary/Seco	ndary (0-12)		College (					•			۱ ,,		E.C.		
ပိ	17. Father's Name	/Eirot Middle	/ act)		4		ANIIC	QUE DEAL		r'a Nama	/Circl Middle		TIQUI		· · · · · · · · · · · · · · · · · · ·	
å											(First, Middle		n Surname	e)		
ို	WILLIAM								IVA	N MA	CMORRI	S				
	19a. Informant's Na	ame/Relation	ship (Ty	rpe. Print)		19	b. Mailing	Address (Street	and Numbe	er or Rura	l Route Numi	ber, City	or Town, S	State, 2	Zip Code)	
	ROBERT C	ARR/HU	SBAI	ND		2	23 BF	ROAD ST.	CRUM	PTON	, MD 2	1628	<b>:</b>			
	20a. Method of Disp 1 ☐ Burial 2		۰ ۵			b. Place of cemete	of Disposit	tion (Name of atory or other pla	ce)	D	ate	20c. l	Location - (	City or	Town, State	
	4 □ Donation					HESA	PEAKE	E CREMAT	'TON	5/8/	2008	STE	'VENSI	7 T T T	LE, MD	
i	21. Signature of Fu	neral Service	e Licens	ee <sub>2</sub>			22.1	Name and Addre	ess of Facilit	tv					H-So- Sales	
	Bu	if St	121	elle	nher	1)	37	ELLOWS. 70 W. CY	HELFE PRESS	NBEII ST.	$egin{array}{ccc}  ext{N} &  ext{NE} \  ext{MILLI} \end{array}$	WNAM NGTO	I FUNE N. MI	ERAI 21	LHOME 1651	
	23a. Part1. Enter the	he disease, o	or compl	ications that	caused the de	eath. Do									Approximate Interval Between	
	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or continuous Afficial Continuous A													Onset and Death		
	resulting in death)	n	-	-	or as a cons			DISKR	<b>3</b> €					-	4 years	
				Due to	or as a corre	sequence	01).									
ē	Sequentially list con if any, leading to im	nditions,	. I t	Due to	(or as a cons	sequence	of):							$\rightarrow$		
듩	Cause (Disease or	injury	<											- 1		
Ха	that initiated events resulting in death) L			Due to	(or as a cons	sequence	of):									
<u>8</u>																
反				3												
Ĭ,	IF FEMALE:		,	3c. If yes, ou	teeme of ore	ananov		-0-50								
lan	23b. Was decedent in the past 12		1	1□Live I	ointh 2 F	etal deat		ctopic pregnanc	y				e of deli nth	f delivery Day Year		
Sic	1 ☐ Yes 2 € 9 ☐ Unknown	¥No		4∐Pregi 9∐Unkn	nant at time o own	of death	5∐C	Other (specify) _					11101		Day (Oa)	
Physician/Medical Examine	Part II. Other signif	loopt cardit	ione	ntributio - to -1	ooth hut and	ranulăi e c	in the	Adhila a a 1	an in Dest		00 - 011	Ash s = -		dia	M	
2		*Cha		nunbuung to a	eatri but not i	resulting	in the unde	enying cause giv	en in Paπ i.						the cause of death?	
9	11/0,	reuc	) / `								1	Yes 2	2 No	3∐ Pr	obably 4 Unknown	
Complete											24a. Was		24b. V	Vere au	topsy findings available	
E												ormed? 2 <b>Ω</b> PN	l d	leath?	completion of cause of 2 ☐ No	
യ	25. Was case refer	red to medica	al						26 Place	of Death	1  Yes  Check only	- 1	10 }	☐ 163	2010	
0	examiner? 1 ☐ Yes 2 <b>∑</b>	'No	F	lospital:	Inpatient 2	2   ER/O	utnatient	3□ DOA Oth	or.		ne 5 ☐ Res		6 DOth-		-16.1	
=	27. Manner of Death			28a. Date	of Injury	28b.	Time of	28c. Inju			28d. Describe				cny)	
	1 Natural 2 Accident	5 ☐ Pendi invest	ng igation	(Mon	th, Day Year	"	Injury		rk? Yes 2∐l	No			•			
3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office											8f. Location	Street a	nd Numbe	er or Bi	ural Route Number,	
	4 ☐ Homicide	deteri	mileu	build	ing, etc. (Spe	ecify)					City or To	wn, Sta	te)		,	
	29a. Certifier	1 Certifvi	ng Phys	sician; To the	e best of my l	knowleda	e, death o	occurred at the ti	me, date an	id place s	and due to the	cause/	s) and ma	nner 25	sstated	
Medical	(Check only one)	2 Medica	I Exami	ner: On the b	asis of exam ner stated.	nination a	nd/or inve	stigation, in my	opinion, dea	th occurr	ed at the time	, date a	nd place, a	and due	e to the cause(s)	
ĭĕ	29b. Signature and	title of certific	er					29c. Licens	e number			29d. D	ate signed	(Mont	h, Day, Year)	
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	30. Name and addre	ess of persor Stode						int) B-Jw.	6	i	01.		1	^-	0 21620	
_ 1	10010	21000	スローン	1 me	)	/ /	00	W July	√	Γ.	( C2) -	477	W	IV	1 2/6/0	

3. Time of Death

DHMH 17 Rev 1/2001

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ms

State

Registrar

31. Date filed (Month, Day, Year)

MAY -

8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 00:48 M 2008 /Medical 4c. County of Death **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTMORE MARTLAND MEDICAL CENTER NIVERSITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1XM 2□ F Director 198-30-6905 6/13/1941 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 Yes 2 No Director KENT MD ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edica Examlner must be 21113 HAVEN RD. 21661 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) COMMUNITY DEVELOPMENT HOUSING 12 4 COUNTY marked other Item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 is marked other Be ို HARRY FRANKLIN CANAN JANET MAY MEDLAR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA LOUISE CANAN/WIFE 21113 HAVEN RD. ROCK HALL, MD 21661 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or = 5 4 Donation 5 Dother (Specify) CHESAPEAKE CREMATION 5/5/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME CHESTERTOWN, MD 21620 130 SPEER RD. 23a. Part1. Enter the disease, or coeffications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PREUMONIA **Physician** 10 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VEUTROPENIA Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed CHROME KIDNEY DISEASE as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical led by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 4☐Pregnant at time of death I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2□ No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 200 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manyer of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

within 24 hours after death To the Funeral Director; Hospital

> 15 ms

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifler

31. Date filed (Month, Day, Year)



29c. License number

1356486039

BALTMORE

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day HORNE 12:41 AM OBERT APRIL 25 2008 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner NURSING & REHAB CENTER HESTERTOWN CENT 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 498 44 8702 Director MISSOURI 3 UNIL Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at HESTERTOWN MD 1 Yes 2 No KENT Funeral Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 203 21620 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 4.5. GOVERNMENT al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 ELATIONS permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Item 27 is marked othe
any Injury or other trainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KOBERT SEMALL 2 HORNE ULIVE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 E.1 CHESTERIONN KEKR 21620 244 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 Removal from State 4/26/08 4 □ Donation 5 □ Other (Specify) HESTER 22. Name and Address of Facility
MARVIN V. WILLIAMS, JR. FINNERAL DIRECTOR 21. Signature of Funeral Service Licensee MARVIN V CHESTERTONA, MD 2/600 HERUS WAY 205 GREEN 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** were /Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of presence or righty that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending Investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: Hospitai

within 2. To the I

State Registrar 31. Date filed (Month, Day, Year)

title of certifie

Name and address of person who completed car

29b. Signature at

death (Item 23a) (Type, Print)
100 SKEEK R) STES CHESTOR TOWN,

29c. License number

29d. Date signed (Month, Day, Year)

			Please Type or Print in Bl	lack Ind	delible In	k. Ensure A	II Copies	Are Legi	ible.			
			State of Maryland				Mental Hy	giene				
				Cer	rtificate c	of Death	2. Date of De	Reg. No.	9.00	3. Time of Death		
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  Luther Gene Crouse				May 7,	2008	Year	11:00a <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution, give street and number)  1602 Thomas Road			n, or Location of Deatl ashington	1	4c. County		ornes		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Ye	ar If Under 24 Hrs.	Prince G			lace (State or Foreign		
В	Director		506-22-3413 1 <sup>□XM</sup> 2□F 8	4 Yrs.	Months Da	ys Hours Min.	Apr. 19	, 1924	Kans	sas		
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Lo	cation				1	0d. Inside City Limits		
	Mary I-f sho fied a	tor	MD Prince Georges Fort	Wash	ington					1 ☐ Yes 2X No		
	th the or 28a e noti	Direc	10e. Street and Number	_ nusit	10f. Zip Cod	e		10g. Citizen of	g. Citizen of What Country?			
	ath wi	ral	1602 Thomas Road		2074			U.S.A.	ce - Americ	on Indian		
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dikal Examiner must be notified at	Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married	. 13.	Was Decedent of If Yes, specify (	of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or No to Rican, etc.)	Bla	ick, White,			
036	urs af al'', or Examl	ρ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1943		1 □ Yes 2 □ <b>X</b> I	No Specify:		Speci	<sup>fy:</sup> Whi	te		
5-0	72 ho 'natur dical I	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Oc kind of work do	ne during most of wo	rking	16b. Kind of E	Business/Ind	dustry		
121	within sne. Ithan "	du	Elementary/Secondary (0-12)  College (1-4or 5+) 5+	Engine	DO NOT use re	tired)		U.S. (	Govern	nment		
<b>d</b> 2	filed Hygid Sther ent, th	Be Co	17. Father's Name (First, Middle, Last)	21191111		18. Mother's Nar	ne (First, Middle			11.10		
/lan	uld be Vental Irked (	To B	Luther Crouse			Muriell	e Cline					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)			eet and Number or Ri		-		Code)		
e)	1 and Health Pm 27 ther to		Louise C. Crouse/ Wife  20a, Method of Disposition 20b. Pla	ace of Dispo	sition (Name of	Rd., Ft. W	Date	20c. Location		own. State		
Baltimore,	ages ent of l t: If ite y or o		1 □ Burial 2 N Cremation 3 □ Bemoval from State Ce	emetery, crer	matory or other ematory	place)	9. 2008	Waldor	-			
ali;	mit. F partme portan Injur		21. Signature of Funeral Service Licenses			Idress of Facility Hur						
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.O. Box 6	he death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	⊒Ectopic pregna □ Other <i>(specif</i> )				ate of delive	ery Day Year		
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ords	w require been sig should b						1 🗆	Yes 2	3 ☐ Prot	oably 4 Unknown		
Il Records,	The law ate has b page 2 sl	Completed					24a. Was auto perl 1∐ Yes	s an 24b ppsy ormed? 21200	. Were auto prior to co death? 1 ∐ Yes	psy findings available mpletion of cause of 2 No		
Vita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   IF	-D/O-44		Other:	ath (Check only					
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	To the within 2 To the comple	Med	29b. Signature and title of certifier	1	29c. Lic	ense number	p)	29d. Date sign	ed (Month,	Day, Year)		
	> - 0		JAN HUM	M		2)0021	4-	5	18)	13		
	2 R 1 1 1		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	1/1A	DER	i mo	20	853		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ture	/ \\\	11. 00.		,				
	Registi		31. Date filed (Month, Day, Year)  32. Resistrar's Signat MAY 0 9 2008	K A	Sparke							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State		State of M	aryla	nd / Depa	artme	nt of He	ealth a	and M	ental Hy	gier			
		Registrar				Ce	rtifica	te of D	eath			Reg. N	No. 200	8	1688
Physicia	an	Decedent's Name (First, I									2. Date of De		Day Year		Time of Death
/Medic		Robert James									May		7 2008		3:45 P <sup>M</sup>
Examin	er	5101 55 55						of Death		4	4c. County of De	ath			
Funeral	•	5. Social Security Number	ring 6.5		o /In uro	last birthday)		La Pla	ita If Under	24 Uro			Charle		
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th the	Director	10e. Street and Number				14 1 14 6	$\overline{}$	p Code				10g. C	Citizen of What C		
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6 after dez or items niner m	Funeral	11. Marital Status 1 ☐ Never Married 2X	Married	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	Ever in U	I.S. 13.	Was Dece f Yes, spe	edent of Hisp ecify Cuban,	panic Orig , Mexican	gin? (Spec n, Puerto R	cify Yes or No lican, etc.)		14. Race - Am Black, Whi		dian,
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Ylan ould be I Mental narked of natic ev	To Be	Edward A. Coo		· · · · · · · · · · · · · · · · · · ·					Ma	ary Wa	allish		-,		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relat  Janet Coo				19b. Mailin 5404	g Address Well	Sprin	d Numbe	or or Rural ad La	Route Numbera Plata	er, City	or Town, State, Maryland	Zip Code	9) 546
More		20a. Method of Disposition  1 □ Burial 2 □ Cremati 4 □ Donation 5 □ Othe	on 3	Removal from State	1	Place of Dispos cemetery, cren	natorý or d	me of other place)	i	Dai			Location - City or	-	
alti mit.   partim partim portai	Ì	21. Signature of Funeral Sen			St	. Jose		nd Address	Ma of Facility	y 14	, 2008	Po	omfret,	Mary	land P.A
<b>a</b> aa <b>a</b> a a		Smilt lif		M01458		21	l St.	Mary	's A	ve. I	La Plat	ta,	Marylan	d 20	10me, P.A 1646
2000		23a. Part1. Enter the disease shock, or heart failure.	e, or com List of ly	plications that caused one cause on each iin	the deatl	h. Do not ente	r the mod	de of dying,	such as o	cardiac or i	respiratory ar	rest,			oximate val Between
Physician /Medical		immediate Cause (Final disease or condition resulting in death)		a. <u>L</u> U	5	5 C		(C						Onse	et and Death
Examiner		3		Due to (or as a	conse	uence of):									
151 A 151 A	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b Due to (or as a	consequ	uence of):									
o, executed in and ial-transit	ľ	Cause (Disease or injury	1												
e exercian ar	ĽŽ	that initiated events resulting in death) Last		Due to (or as a	consequ	uence of):									
68760, ifficate be executed globysician and as the burial-transit	2			d											
9 # # 0 B		IF FEMALE:			-										
ords, P.O. Box (requires that the death certified signed by the attending rould be detached for use as feel by Physician Median	Sicially	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetai	ideath 3 ∐8	Ectopic pr Other (sp						23d. Date of del Month	ivery Day	Year
that the de detached f		9 Unknown		9∐Unknown		_									
S res t		Part II. Other significant cond	ditions co	ontributing to death but	not resu	Ilting in the und	lerlying ca	ause given i	n Part I.	_			use contribute to		se of death? 4 ∐Unknown
law as b 2 st b	2										24a. Was a	<u> </u>	24b. Were au	topsy fin	dings available
r Vital Rayslean: The sis certificate hadirector, page											autops perfori 1⊟ Yes	ned? 217 No	prior to death?	completio	on of cause of
Vital sician: Ti certificate rector, pa		25. Was case referred to med examiner?	_ ⊢					26	6. Place o	of Death (C	Check only on	_	o To res	IN	10
To This ald dis	1	1 Yes 2 No		Hospital: 1 ☐ Inpatien		R/Outpatient	3 DO	Othor					6 □Other (Spec	cify)	
on or oling Phy. After thi funeral current funeral current cur	ľ	27. Manper of Death 14⊒ Natural 5 □ Pen		28a. Date of Injury (Month, Day		28b. Time of Injury		Bc. Injury at Work?			I. Describe ho				
Division  I or Attending after death. Director: After d in by the fune		3 Suicide 6 Cou		29a Place of injur	. At hor	ma fame -1	M		2 🗆 No	-					
		4 ☐ Homicide dete	mined	28e. Place of injury building, etc.	(Specify)	)	et, ractory,	office		28f.	Location (St City or Town	reet ar , State	nd Number or Ru e)	rai Route	e Number,
		29a. Certifier 12 Certifier (Check only 2 Medic	ying Phy	sician: To the best of	my know	vledge, death o	occurred a	at the time,	date and	place, and	due to the ca	ause(s	) and manner as	stated.	
o the Hosp ithin 24 hou o the Fune ompletely fi	-	one)		iner: On the basis of e	xamınatı ed.	on and/or inve	sugation,	in my opini	on, death	occurred	at the time, d	ate and	d place, and due	to the ca	ause(s)
To with	-	29b. Signature and title of certi	Tier C	\			29c.	License nu	mber		2	9d. Da	te signed (Month	, Day, Yo	ear)
7	-	O Name and address of	01					17 9 G	5	7	1	9	18/0	1	
MP10	3	0. Name and address of person	on who co	ompleted cause of dea	tn (Item :	23a) (Type, Pr	int)	010		,	10 N	1	061	11	
State	3	1. Date filed (Month, Day, Yea	-	32. Revistrar	s Signatu	lre L	1				/- /)	2	00	10	
Registrar		MAY	0 9	2008 Flore	w.	D B	MALL								ŀ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ~ YI9PIM 510 M 5008 AIMD mas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Bey 0601 0 tous ( 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Jan. 15, **Funeral** 1<u>951</u> Min. 1**⊠** M 2□ F Months Days Hours Massachusetts Jan. 212-54-1998 57 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it we Modical Examination to item at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2X No Charles Waldorf Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20602 U.S.A. 3575 Old Washington Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Private Investigator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Joseph Crispin Dorothy Louise Beaman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13745 Jacobs Road, Mt. Airy, Maryland, 21771 Jennifer Wetsel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 10, 2008 Waldorf, Maryland **Huntt Crematory** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3035 Old Washington Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a rest, shock, or heart failure. List only one cause on each line. Waldorf, Maryland, 20601 Approximate Interval Between Onset and Death Immediate Cause (Final Physician mocrania disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 200 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ax Due to (or as ) consequence of): Examine mP burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autons perform 1 ☐ Yes director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760 n 24 hours after death.

Ne Funeral Director: Af completely within 2 To the the

Registrar

31. Date filed (Month, Day, Year) State MAY 09

29b. Signature and title of certifier

Dany Westerband,

8600 Old Georgetown Road, Bethesda, Maryland, 20814 gistrar's Signatur 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D42135

29d. Date signed (Month, Day, Year)

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Μ. DeFabio May 6, 2008 **Physician** Florence 1:55 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 8. Date of Birth Month, Day, Sept. 7, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 82 1 □ M 2√√ Iowa 488-22-0725 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes XXXIo Hillcrest Heights Directo Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 2 must be n LISA 2800 Colebrooke Drive 20748 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23, any or other traumatic event, the Medical Examiner must Completed by Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DQ NOT use retired)
Self Employed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Niemier Lucinda Jane Henry Fred 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3100 Ritchie Road Forestville, Maryland Dino Vinciguerra / Per. Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: If any Injury or once. Arlington Nat. Cemetery 05/22/2008 Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatur / Funeral Since Lice see 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): ORSTRUTIUP Lung Disoure CHRMic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed purum c physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕮 No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3XX Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy perform Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA > Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rond, Fant WASHington, Wanylon

Registrar DHMH 17 Rev 1/2001

State

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32. Registrar's Signatu

Milliam

MAY 0 9 2008

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav Year 2000M 0 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Olney If Under 1 Year | If Under 24 Hrs. MONTGOMERY General Hospital Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 26, 1941

Days

Silver Spring

10f. Zip Code

1 ☐ Yes 2√☐ No

16a. Decedent's Usual Occupation

20b. Place of Disposition (Name of cemetery, crematory or other place,

1 M MX

Montgomery

14722 Blanton Road

15. Decedent's Education (Specify only highest grade completed)

William H. Campbell

William T. Campbell,

19a. Informant's Name/Relationship (Type. Print)

66

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:

College (1-4or 5+)

(Son) Sr

10c. City, Town or Location

213-42-6908

1 Never Married 2 Married

3 ☐ Widowed 4 ☑ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

12th

17. Father's Name (First, Middle, Last)

Usual Residence of Decedent

10a. State

MD

11. Marital Status

10e. Street and Number

Directo

Funeral

\$

Completed

Be

၉

Hours

20905

(Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

Blanton Rd,

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mildred Budd

Maryland

10g. Citizen of What Country?

U.S.A.

16b. Kind of Business/Industry

Silver Spring,MD 20905

20c. Location - City or Town, State

14. Race - American Indian,

Specify: Black

Montgomery Co.

Public Schools

10d. Inside City Limits

1 ☐Yes 2 XNo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any hipry or other traumatic event, the Medical Eventries must be notified at once. Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 Berial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)	ASII Melio.	rial Cem 5/1		Spring, MD						
	21. Signature of Funeral Service Licer			nowDen Foner on St, Rockvi							
	23a. Part 1. Enter the disease or com shock, or heart failure. List only	plications that caused the death. Do not enter to one cause on each line.	he mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between						
	Immediate Cause (Final disease or condition resulting in death)	Onset and Death									
caminer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b									
edicai Ey	resulting in death) East	Due to (or as a consequence of):									
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 1 □ Live birth 2 □ Fetal death 1 □ Company Signature 1 □ Live birth 2 □ Fetal death 1 □ Live b										
red by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to										
				autopsy performed?	Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 ☑No						
9	25. Was case referred to medical examiner?	U(b-l)		ath (Check only one)							
2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing F	dome 5 ☐ Residence 6 ☐ Oth	ner (Specify)						
ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurr	red						
Certification: 10	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,						
Medical											
Ξ	29b. Signature and title of certifier		29c. License number	29d. Date signe	d (Month, Day, Year)						
	Paul Barrer	MD	M0000335	53, 2008							
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Prir	nt)	May							
	Paul Bornen 181		#327 Olne	y MD 2083	2						
r	31. Date filed (Month, Day, Year)  MAY 0 9	2008 32. Rigistrar's Signature	sole?	,							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 24 2008 Willie Lee Dennis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico ake HOSDICE at the 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours **№** M 2□F 57 July 10,1950 MD 220-52-9087 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XIYes 2□No Delmar Director MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1301 Pine St. 21875 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 XYes 2 No Army
If Yes, Give
Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Press Operator Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgie Leonard Willie A. Dennis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernice L. Dennis/wife 1301 Pine St., Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Medford Cemetery 5/09/2008 Concord, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lewis N. Watson Funeral Home 21. Signature of Funeral Service Licenses alana 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LIVPYA CIRRHOSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CARDIOMYOPATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ♣ 6 24a. Was an autopsy 1□ Yes 24 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053410

U gu

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 8 2008

GHUHAM WARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



6.0 Box 1737 SAVISBURY UP 21802

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4/29/2008 WILLIAM EDWARD DAVIS 4:55A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESTERTOWN HERON POINT Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours **™** M 2□ F CT Director 93 3/31/1915 385-01-2385 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD KENT CHESTERTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1014 HERON POINT 21620 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MATHEMATICIAN CHEMICAL 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RANDOLF DAVIS KATHERINE HELMERICH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET PORTER/DAUGHTER 7 DEER POND RD. CHADDS FORD, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation — 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 4/30/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Aufs 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Disease of linus) that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as the attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the a 9 ☐ Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 21 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 24a. Was an page 2 autopsy performed? certificate 1 ector, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) dir Certification: To After this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation М 1 TYes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jivision or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: within 24 hours ther death.

To the Funeral Director A completely filled in by the fu death.

29b. Signatur 30. Name

determined

4 ☐ Homicide

29a. Certifier

29c. License number 0060301 29d. Date signed (Month, Day, Year)

Ind address of person 31. Date filed (Month, Day, Year)

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states.

State Registrar

Medical

2008



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Year Day **Physician** Month 2008 5:45a Hallie E. Friend May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Crofton Rehabilitation Center Crofton Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 88 1/28/1920 Director 236-22-5560 West Virginia Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Marvland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 2131 Davidsonville Road 21114 USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ADI 12 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maggie Oden David Newton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Beeler - Daughter 2301 Penn Place, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/12/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses heatlans 3401 Bladensburg Rd., Brentwood, MD 12men 20722 23a. Part 1. Enjer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dement y-Pan /Medical resulting in death) Due to (or as a consequence of): entensive CardioVasculus Dispas y Examiner Due to or as a consequence of): Securately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ig physician and as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) signed by the a I∏ Yes 2∏ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 25 Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: nours after death. neral Director: After this co y filled in by the funeral dire 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or within 24 hours a To the Funeral C

State

DHMH 17 Rev 1/2001

Medical

2008 MAY 0 9 Registrar

29a. Certifier

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

300 Gallant FOX LN BOWIEMD20715

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera
ch	Sta Registr

		For State Registrar	1 1040	State o	f Marylar	nd / Depa		t of H	ealth :	and M	lental Hy		2008	1689	possession and the same of the	
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Funeral		Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						ntor 1 Year Days			8. Date of Birt	h	eorge's	jn		
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be od o	To Be	17. Father's Name (Fi									(First, Middle, McLauri:		Surname)			
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rsiclan:	o Be	25. Was case referred examiner?  1 ☐ Yes 2 ☑ 100		Hospital: 1 7	Inpatient 2	1 FB/Outnatier	nt 3 □ DO	Δ Othe	r.		n <i>(Check only o</i> me 5 ☐ Resid		Clother (Cae		_	
£ ± =	- 1	27. Manner of Death	5 Pending investiga	28a. Date (Mon	·	28b. Time o Injury		8c. Injury Work			28d. Describe h			Спу		
tal or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Place	of injury - At he ing, etc. <i>(Specil</i>		eet, factory	, office			28f. Location (5 City or Tov	Street and vn, State)	l Number or Ri	ural Route Number,		
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To t with To t	Ž	29b. Signature and titl	10	Um.	Mi			50	number			29d. Date	signed (Mont	th, Day, Year)		
		30. Name and address	LVIEW		coulf 5	int 3	Print)		100 Y	Yazda Tuus	ni,M.D.	~ <1	0 20	744	e-th	
State Registra	ır	31. Date filed (Month, MAY 0 9		Blane)	Registrar's Signa	ature	•									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16895

illela i lewe		1- For State Certificate of Death Registrar		J
Physic	cian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year All 2009  2. Date of Death 2. Date of Death 2. Date of Death 2. Date of Death 2. Date of Death 3. Time of Death 2. Date of Death 4. Day 4.	
al Exar	nine		IVIAY 3, 2006	4
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e, MD I and 2 sho Health and item 27 is	trau	20a. Method of Disposition 20b. Place of Disposition (Na	ame of cemetery, Date 20c. Location - City or Town, State	٦
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760, icate be ex g physician	the bu	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	23d. Date of delivery  h 3 Ectopic pregnancy Month Day Year	
O. Box 687 that the death certific	use as	past 12 months?  4 Pregnant at time of death 5 Other (Sc	1	
. <b>Bo</b> he deat	hed for	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying the underlyin	ng cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
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<b>ds,</b> require been si	should be deta	Coapleted	24a. Was an autopsy findings available prior to completion of cause of	le
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al R	rector, page	25. Was case referred to medical	26.Place of Death (Check only one)	-
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Div pital o ours af	filled	4 Homicide determined (Specify)		_
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I	completely filled in by the		the time, date and place, and due to the cause(s) and manner as stated.  my opinion, death occurred at the time, date and place, and due to the cause(s)	
To 1	com	and manner stated.	29c. License number 29d. Date signed (Month, Day, Year)	
10		Don minh, MD.	O.C.M.E. May 4, 2008	
e C		30. Name and address of person who completed cause of death (Item 23a)	n Street Baltimore MD 21201	
		Dolling VIII October 1997 And 1997 Projector's Signature	n Street, Baltimore, MD 21201	
	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature		

			1 - For State of Marylai Registrar		triment of Hea tificate of De				08	16895		
N.	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day	Year	3. Time of Death		
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36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1  Never Married 2  Married 1  Yes 2  No If Yes, Give 3  Widowed 4  Divorced 1  Yes, Give Year or Dates:		1 □ Yes 2 🗷 No S			Specif	y:	White		
15-0036	2 hour atural cal Ex		15. Decedent's Education	16a. Deced	lent's Usual Occupation	n	11	16b. Kind of B	usiness/Ind			
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	ra ra		Virginia L. Burnham - Daughter	1	203 Ridgemede Road, Baltim							
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Baltimore,	permit Depart Import any in		21. Signature of Theral Service Hopingee	(i) Hi	!. Name and Address o nes-Rinaldi I 800 New Hamps	Funeral Ho	ome, Inc. nue, Silv	er Spring	, Mary	land 20904		
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II a	ysician: The I is certificate ha director, page 3	BeC	25. Was case referred to medical examiner?		26	6. Place of Death						
or ^	Physician: this certific	T0.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 [	<del>-,</del>		4□ Nursing Ho				)		
	ding F h. After funera	ion:	27. Manner of Death  1 Natural  2 ☐ Accident investigation  investigation	28b. Time of Injury	Work?	2 □ No	28d. Describe	how injury occur	red			
DIVISION	ten leat tor: the	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At l building, etc. (Spec	home, farm, stre cify)			28f. Location (: City or To	Street and Numi vn, State)	per or Rura	l Route Number,		
	e Hospital or Al 124 hours after d e Funeral Direc letely filled in by	S	29a. Certifier 1 Certifying Physician: To the best of my kr	nowledge, death	n occurred at the time.	date and place	and due to the	cause(s) and m	anner as st	ated		
	To the Hos within 24 hd To the Fun completely	edical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.									
	To the le within 24	Me	29b. Signature and title of certifier		29c. License nu			29d. Date signe	d (Month, I	Day, Year)		
,	4		HHOUN		12311	72		Max	8,	2008		
			30. Name and address of person who completed cause of death (Ite	ANTEN		72 0 Cau	unbir	- Mr	) ;	2074		
	Sta Registr	- 1	31. Date filed (Month, Day, Year) 32 degistrar's Sign	nature	adi							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nq. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:55 PM Andrew Thomas Fox, Jr. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Westminster Carroll 2905 Littlestown Pike 8. Date of Birth (Month, Bay, Y If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>Yea</sup>1<sup>9</sup>28 Min. Months Davs Hours 1 🔀 M 2 🗆 F 220-24-5047 79 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No Director Carroll Westminster Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ò 21158 USA 2905 Littlestown Pike items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **N**No P Baltimore, Maryland 21215-0036 1 ☐ Yes 2 INO Specify: ò Specify: White 3 ☐ Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4or 5+) Sweetheart Cup Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Gertrude Hodges Andrew T. Fox, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1050 Deer Park Rd., Westminster, MD 21157 Bette Rae Harris/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Carroll Cremations Inc. 05/07/2008 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, Maryland 21. Signature of Funeral Service Licenses Prints Pure far Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an page 2 s has certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 20 No Other: 2 1 ☐ Yes 3□ DOA 4 ☐ Nursing Home 2 ER/Outpatient 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗀 No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is

II 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year)

NASHINGTON HOTS

State Registrar

Medical

29b. Signature and title of certifie

4 Homicide

29a. Certifier

and manner stated.

**ORIGINAL** 

		1 = For State Registrar	State of Mary		oartmen e <i>rtificat</i>			Mental	Hygien Reg. N	211	08	16893		
Mary 4	F	Decedent's Name (First, Middle, Last)							of Death			3. Time of Death		
Physicia /Medic		Elaine S. Gibbo	ns					May			2 <sup>Year</sup> 2008	12:35A <sup>M</sup>		
Examin	7 5	4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Lo	ocation of Dea	ath	4	c. Count	ty of Death	72 0 0 0 1 2		
	Ю	Charles Co.Nurs	ing & Reh	ab.Cnt	La	a Pla	ıta			Cha	arles			
Funeral		Social Security Number     6. Sex		yrs. last birthda	y) If Under Months		f Under 24 Hr Hours Mir	s. 8. Date (Mont	of Birth th, Day, Year	-)	9. Birthpl Count	ace (State or Foreign try)		
Director		218-24-0673	M 2(XF)	79 Yrs.		54,5			31,19			resota		
and		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or	Location						10	0d. Inside City Limits		
Aaryli e e ho	ō	MD Charles		La Plat								1 ∐ Yes 2 <b>∑</b> ⊠yo		
the N	Director	10e. Street and Number			10f. Zip	Code			10a C	itizen of	What Coun	try?		
with Sa or		10200 La Plata	Road			20646	5				S. A.	-		
15-0036 72 hours after death with the Maryland "naturel", or Itams 23a or 28a-f ehow adjoal Exeritive Industrictified at	Funeral		12. Was Decedent Ever	in U.S. 13	3. Was Dece	dent of Hisp	anic Origin? (	Specify Yes	or No-		ce - America			
<u> </u>		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, spe	cify Cuban,	Mexican, Pue	rto Rican, etc	c.)		ack, White, e	etc.		
ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	XLXNo	Specify:			Speci	<sup>⊮y:</sup> Whi	te		
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Ly ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT u	se retired)	ring most of w	<b>y</b>						
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Iryiand 2 should be filed of Mental Hygi markad other imatic event, I	Be	17. Father's Name (First, Middle, Last)	G - 1 1 -			18			irst, Middle, Maiden Surname)					
arylc should nd Mer marks marks	은	Peter Anthony								e Nelson  mber, City or Town, State, Zip Code)				
12 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		19a. Informant's Name/Relationship (Typ										/IIn 7 9		
C = M =	1 3	Deborah A. Murph 20a. Method of Disposition		Ob. Place of Dis			Mattin	Date Date			nicsv - City or To			
8027		1√Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, c	ematory or c	other place)	May	7						
Baltimore, permit. Pages 1 ar Department of Her Important: If item any injury or othe		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		old Fie								e, MD		
Baltim permit. Pag Department Important: I any injury o once.		Lor 1 RA	1	0.641	22. Name a		F	aymor	nd Fu	ni.;	Servi	ce,P.A.		
d5. 14. 14.51		23a. Part1. Enter the disease, or complic								Рта:	ta, M	ID 20646 Approximate		
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1103	1	1 . /	1.00		,			Interval Between Onset and Death		
Physician /Medical		disease or condition resulting in death)	Due to (or as a cor	معداط	racy -	au	ure							
Examiner		1	4 nd	Class.	(1)	V	dia	rand						
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	rsequence of):	_ ~	AND T	0 /	, C	•					
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cate be executed physician and the burial-transit	edicai	L d												
intifica	Med	IF FEMALE:												
death certifi death certifi e attending ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1☐Live birth 2☐		I □Ectopic p	regnancy					ate of delive	ry Day Year		
the dea	Sic	1 ☐ Yes 2 NNo 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown	of death 5	Other (sp	pecify)				141	Ontin	Day Teal		
that the death certificated by the attending of detached for use as	Ph)	Part II. Other significant conditions conf	tributing to death but no	t resulting in the	un dorbing a		in Bort I	230	Did tobacco	USA COL	atribute to th	e cause of death?		
ଓ ଓ ଜୁଞ	by	Fatti. Stroi significant conditions con	modaling to death but no	resulting in the	diragnying c	ause given	III Fail I.			2 🗆 No	3 Proba			
HECOLOS he law requires a hes been sign ige 2 should be	Completed								-		Λ.			
e law bes l	du								Was an autopsy performed?	24b.	Were autop prior to con death?	osy findings available npletion of cause of		
_ F 36 G								101		0	1 ☐ Yes	2 □ No		
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OVISION or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm,	street, factor	y, office					ber or Rural	I Route Number,		
s afte	Sert	4 Homicide determined	building, etc. (Sp	oecity)				City o	or Town, Sta	te)				
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he Fi	edical	(Check only	er: On the basis of exa- and manner stated.	mination and/or	Investigation	, in my opini	ion, death occ	curred at the	time, date ar	nd place	, and due to	tne cause(s)		
To t com	Σ	29b. Signature and title of certifier	0			. License n		` _	29d. D	ate sign	ed (Month, L	Day, Year)		
		Houlday	NMD			DOO	6165	2	0	5	18/0	८००८		
6		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Typ	e, Print)	.1 .4	ا ا	4 10	2 - 1					
		Suite 101, 6	POST OF	ive Kd	, W	ricla	X/ I	M(I)	200	002				
Sta Registra		31. Date filed (Month, Day, Year) MAY 2 3 2008	3. Registrar's S	nynature	will		1	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MAY 2008 HERMAN GRAVES 8:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB • 9 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1930 Months Days Hours Min. 1 € M 2 □ F 241-42-4272 78 NORTH CAROLINA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be nothing at Director 1 ☐ Yes 2 ☐ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 DIVISION AVENUE N.E. 20019 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No ARM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2√ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio BLACK If Yes Give Specify þ Specify 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) STOCK CLERK PRIVATE 12TH permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SPENCER GRAVES LIZZIE BOLDEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACIE M. GRAVES/WIFE 406 DIVISION AVENUE N.E. WASHINGTON, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - Citron Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State BROWN CHAPEL MISSIONARY 5/10/2008 GIBBSONVILLE, NORTH 4 ☐ Donation 5 ☐ Other (Specify) Cispature of Funeral Service Lice y ee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of doing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (b) as a consequence of) Examiner Sequentially list conditions, Due to (or as a nonsequence of) Examine tury, leading to himedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical ned by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1∐ Yes Medical Certification: To 1 Inpatient ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 1 3 2008

18549

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

29c. License number

Jum. 1485 P. 3001 Hospita

29d. Date signed (Month. Day, Year)

	*		1 - For Amend Items 23a, 2	te of Marylan <b>per me</b> , g	879 O5	artment of L 122/08dbl tificate of	lealth and M Death	lental Hyg	giene	16900
Ė	Physici		1. Decedent's Name (First, Middle, Last)	HYMAN				2. Date of Dea Month	Day Year 3, 2008	3. Time of Death 5:51 A M
	/Medio		4a. Facility Name (If not institution, give street FREDERICK MEMORIA			4b. City, Town, o	Location of Death	Abrir	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex None 1 □ M 2	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April	y Year) 9. Birth Cou	place (State or Foreign ntry) Land
	/aryfand f show ed at	'n	Usual Residence of Decedent  10a. State    Maryland   Frederick	10c. Cit	y, Town or Lo		lerick			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the Na or 28a-	I Director	10e. Street and Number 505 Coachman Court			10f. Zip Code	1703		log. Citizen of What Cou United S	-
036	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	Ar 1 Never Married 2 Married 1 I	as Decedent Ever in U med Forces? ]Yes 2 [3] No res, Give ar or Dates:	1	L Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 A No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: B	
9500-61212	d within 72 ho giene. er than "natui the Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	oleted) bllege (1-4or 5+)	(Give life, l	dent's Usual Occup kind of work done DO NOT use retired None	ation during most of work f)	ing	16b. Kind of Business/Ir None	ndustry
/land	be od o	To Be C	17. Father's Name (First, Middle, Last) Anthony Hackett				18. Mother's Name	e (First, Middle, ita Hyma	•	
, Mar	ges 1 and 2 should it of Health and Mer If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship <i>(Type. Pr</i> Wanita Hyman / Mot	her	505	Coachmar	Court,	Frederic	r, City or Town, State, Zick, Maryland	1 21703
Itimore	permit. Pages 1 Department of H Important: If iten any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☆Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)		ithsbur	sition (Name of matory or other place g, Maryl	and 7, 2	.008	20c. Location - City or T Smithsburg,	Maryland
Pall	permit Depart Import any in		21. Signature of Funeral Service Licensee	7 M0143	3 1	.06 East Chi	irch Street,	Frederic	nsford P.A. Fur ok, Maryland 2	
8/00,	death certificate be executed  Paramine physician and death certificate as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conseq	uence of):	amnioniti		1	POR DR. MI	Approximate Interval Between Onset and Death
O. Box 6	the death certifica y the attending ph ched for use as th	nysician/Med	in the past 12 months?	/es, outcome pf pregna □Live birth 2 □ Feta □ Pregnant at time of d □ Unknown	ıl death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of deliv	rery Day Year
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	the Hospit in 24 hour the Funera	Medical (	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Cartifying Physician 2 Medical Examiner: Car	To the best of my kno in the basis of examina and manner stated.	wledge, deatl tion and/or in	vestigation, in my c	pinion, death occur	and due to the or red at the time, or	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	With Conf	M	29b. Signature and title of certifier	hede	n)	29c. Licens	39805		$0 + \left(03/2\right)$	200
			30. Name and address of person who completed the STANE THE 31. Date filed (Month, Day, Year)  MAY 2 2 2008	ed cause of death (Iten	FRED	Print) 4001 ERICK N	N7TH ST IEMORIA	REET, 1 HOS	FREDERIC PITAL, NO	CU HD 21701
4	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 2 2008	32. Registrar's Signa	park	,				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Willie Lee Holt 2008 8:24 a.M Mav 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton, MD Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F 241-72-2775 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MD 1 X Yes 2 No Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4311 Ridgecrest Drive 20746 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Convenient Store Franchise Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Galloway William Holt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Holt/Wife 4311 Ridgecrest Dr, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Resurrection ection 5/13/2008 Clinton, MD 22. Name and Address of Facility 6500 Allentown Rd, Camp 21. Signature of Funeral Şenvice License Strickland Funeral Services, Spring, MD Phil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine Due to (or as a consequence of): Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1⊟ Yes 2₽No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

Department of Important: If any Injury or

show r 28a-f shov notified at

p e

r than "natural", or items 23a the Medical Examiner must b

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite rry or other traumatic event, the Medical Examines.

Baltimore, Maryland 21215-0036

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death

and burial-trai attending physician for use as the buria signed t cate has been signated by page 2 should by certificate director After

P.O. Box 68760

Division or Vital Records,

death.

Certification: To funeral To the Hospital or Attendii within 24 hours after death. 
▼ o the Funeral Director: A completely filled in by the fu

1 ☐ Yes 2 🗆 🏖 27. Manner of Death

2 Accident 3 Suicide 4 Homicide 29a. Certifier

(Check only one)

29b. Signature and title of cer

1 Natural

5 Pending investigation

6 Could not be determined

1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of per who completed cause of death (Item 23a) (Type, Print) -350 LIVIN

State Registrar 31. Date filed (Month, Day, Year, 32. Registrar's MAY 1 2 2008

*		For		State of Ma	aryland	l / Depa	artment of I	Health and	d Mental Hy	giene	2008	16902
	1	State Registrar					rtificate of			Reg. No.	2000	
Discontinue		1. Decedent's Name	e (First, Middle, Last	)	•				2. Date of De Month	eath Day	Year	3. Time of Death
Physicia /Medic		Paul J	Jerome Har	ris					May 6	, 200	08	16:08 P M
Examin		4a. Facility Name (/	f not institution, give	street and number)			4b. City, Town, o	r Location of De	ath	4c.	County of Death	1
		Holy (	Cross Hosp	ital			Silver			Mo	ontgomer	У
Funeral Director		5. Social Security N 578-44-79	T#	7	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		rth ay, Year)	35 Lou	pplace (State or Foreign intry) LSA County,
pu *		Usual Residence of 10a. State	Decedent 10b. County		10c City	Town or Lo	cation				1	10d. Inside City Limits
shov	ř		Tob. County									1 Tyyes 2 □ No
the M	ect	DC 10e. Street and Nu	- hor		wasi	ingto	10f. Zip Code			10a Citi	zen of What Cou	21
with a or	ä		ey Branch	Road NW			20011			USA	Zeri or variat coc	interior in the second
er death with the Marylan items 23a or 28a-f show inclust by notified at	Funeral Director	11. Marital Status	J Branen	12. Was Decedent	Ever in U.S	13.1		Hisnanic Origin?	(Specify Yes or N	0-	14. Race - Amer	ican Indian.
fter d	표		ied 2 XMarried	Armed Forces? 1X□Yes 2□1	No		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Black, White	, etc.
urs aft al", or	þ	3 Widowed		If Yes, Give 1 Year or Dates:	959-6	55	1⊡Yes 2 <b>X</b> ONo	Specify:			Specify: B1	lack
72 ho	ted	(Spar	15. Decedent's Edu cify only highest grad	cation	- 1	16a. Dece	dent's Usual Occup	pation	vorking	16b. Kii	nd of Business/I	ndustry
be filed within 72 hours after death with the Maryland tital Hygiene.  Id Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Madical Evar, included to colline.	Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5	i+)		kind of work done DO NOT use retire		rorking	77	0 0	
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d be fill he ental he ced out	To Be	Thomas E.	(First, Middle, Last) . Harris					l	lame (First, Middle ed I. Thu		,	
permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, Its Medical Evarones.	F		ame/Relationship (7) Harris —			19b. Mailir 6235	ng Address (Street Piney B	and Number or ranch Ro	Rural Route Numl	er, City o	r Town, State, Z gton, DO	ip Code) C 20011
of Hea		20a. Method of Dis			20b. Pla	ace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or T	own, State
E Page tment tant: It		4 Donation	☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	*		ntico	National	Cem. 5			ngle, VA	
permii Depar Impor any Ir once.		21. Signature of Fr	injeral Service Licens	SMSO					ell & Joh Ave., Tem			L Home PA 4D 20748
		23a. Part . Enter t	he disease, or ampl irt failure. List of y o	ications that caused ne cause on each lie	the death.	Do not ent	er the mode of dyi	ng, such as card	liac or respiratory	arrest,	1000 W	Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final	. Congesti	ve He	eart F	ailure					Onset and Death
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ificate g phy is the	edic			J								
To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is dompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2[ 9  Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		-	23d. Date of deli Month	very Day Year
that the detac		Part II. Other signif	ficant conditions co	ntributing to death b	ut not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
uires n sign id be	d by								1 🗆	Yes 2[	□ No 3 □ Pro	obably 4X Unknown
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n: Th ficate r, pag									1 □ Yes	2 <b>X</b> No	1 ☐Yes	2K No
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r Atte ter deε irecto r by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hon c. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To	(Street an	d Number or Ru	ral Route Number,
urs af rral Di			V.									
e Host 1 24 hol e Fune letely fi	Medical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exami	sician: To the best ner: On the basis o and manner sta	f examinati	rledge, deat on and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the ccurred at the time	e cause(s) , date and	) and manner as I place, and due	stated. to the cause(s)
To th withir obmp	Me	29b. Signature and	title o certifier				29c. Licens	se number		29d. Dat	te signed (Month	, Day, Year)
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State Registrar

Julie Fox, M.D. 31. Date filed (Month, Day, Year)
MAY 1 2 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie Fox, M.D. 2101 Medical Park Dr., Silver Spring, MD 20902

32. Registrar's Signature

May 7, 2008

			1 - For State Registrar	State of M	laryland /	Departm <i>Certific</i>			Mental Hyg	iene	8 16903
	Physici /Medi		1. Decedent's Name (First, Middle, Dohta D	Pelvon H	orton,	Tr			2. Date of Deat Month		Year 8 3. Time of Death 03 24 Am
	Examir	ner	49. Facility Name of the not institution, of Howard County	1 benevel	Hospit	lel 1	Colies	Location of Dea	MD	4c. County	ward
	Funeral Director		Social Security Number  /6  Usual Residence of Decedent	. Sex 7. A. 1 [X]M 2 ☐ F	ge (In yrs. ast bi	Yrs. Mont	hs Days	Hours Mir		<sup>Year)</sup> 2008	Birthplace (State or Foreign Country)     MD
	Maryland -f show	tor	10a. State 10b. County  MD Wicomi	.co	10c. City, Tow			-			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 422 Hastings St.	,	-L	10f.	Zip Code 21804		11	og. Citizen of W	/hat Country?
036	d within 72 hours after death with the Maryland jene. Ir then "naturel", or itame 23a or 28a-f show the Modical Exaciline result be notified at	þ	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1	?	If Yes,	ecedent of His specify Cubar s 2X No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black	American Indian, K, White, etc. Black
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	is 1 and 2 should if Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship Necole Waters/mo						Rural Route Number,		State, Zip Code)
Baltimore,	Pages 1 and the north of the int: if Item iny or other		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Content of the Conte		'	of Disposition ( ory, crematory) Acres				Salisbu	City or Town, State
Balt	permit. Pages Department of I Important: If Its eny injury or or once.		21. Signature of Funeral Service Lic	Dalfor		22. Name Lewi	and Address	of Facility atson F	uneral Ho	me	
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VIII A	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	0CED10		Cthe		eath Check only one		
Sion of	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director; After this completely filled in by the funeral directors.	<del> -  </del>	27. Mannar of Death  1		ıry 28b.	Time of njury M	28c. Injury Work	4   Nursing	Home 5 Reside		
Ž Ž	ital or Att irs efter de rai Directo led in by ti	Certification:	3 Suicide 6 Could not determine	d 286. Place of In	ury - At home, fa c. (Specify)				City or Town	State)	r or Rural Route Number,
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	2∰28 0≪V	-	29b. Signature and title of certifier	ellerred	<u>`</u> ,	MO	29c. License	70667	48	04/2	(Month, Day, Year)
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	Sta Registr			008	ar's Signature	front		4			

DHMH 17 Rev 1/2001

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			Decedent's Name (First, Middle, Last)						2. Date of Death	1	3. Time of Death
65	Physici		Steven J. Hughes						Month May 1	0, 2008 Yea	10:30 p.M
100	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)			4b. City, Town, o	r Location of D		4c. County of De	
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-27	Funeral		5. Social Security Number 6. Sex			ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	1	Sirthplace (State or Foreign Country)
B	Director		579-72-4582 <sup>1図M</sup>	2 🗆 F	54	Yrs.	Months Days	Hours	Hrs. 8. Date of Birth (Month, Day, March 14	1954	D. C.
	D		Usual Residence of Decedent								
	how		10a. State 10b. County		10c. City	, Town or Lo					10d. Inside City Limits
	B Ma	cto	Maryland Washingt	on		Hager	stown				1 ☐ Yes 2X No
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f ehow yit, the Medical Examinar must ke notified at	by Funeral Director	10e. Street and Number				10f, Zip Code		10	g. Citizen of What	Country?
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	ems ems	ine	11. Marital Status	Was Decedent E Armed Forces?		S. 13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Yes or No- querto Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
ð	or li	Y.F.	1 Merried 2 Married 2 Married	1 ⊟Yes 2 📉 N If Yes, Give	10	,	☐ Yes 2X No	Specify:		Specify: 1	lack
9	ural	Q D	3 Widowed 4 Divorced	Year or Dates:						Ot 16 d d D dies	- Andrews
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Maryland 21215-0036	Hygi Hygi ther ant, III	ပိ	17. Father's Name (First, Middle, Last)			110 4	or empro		Name (First, Middle, M		
au	Mental Merked o	Be.	Jackie Hughes					Ваз	bara Palme	r	
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<u>8</u>	d 2 sho th and th and 7 is m traum		Syeeda Hughes - sis						33, Washin		
a)	1 and 2 Health tem 27		20a. Method of Disposition		20b. Pl		sition (Name of natory or other plan			Oc. Location - City	
و	Pages nent of I int: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ Rem	oval from State			ematory or other pla	1		Clinton	Maryland
	ritani njury		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Ге		. Name and Addre		5,2008 MINNICH F		
Baltimore,	permit. Pages Department of Important: If ii eny injury or o			41					levard, Ha		
			23a. Part1. Enter the disease, or complicate		the death						Approximate
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5	ding h. Alte fune	tlor	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year)	Injury	28c. Injui Wo	rk? ∣Yes 2.∐No			
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Division of Vital Records,	or A atter Dire	Certification;	4 Homicide determined	building, etc			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	, State)	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerat Dire tor: Atter this certificate his completely filled in by the tuneral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physici 2 Medical Examiner	an: To the best of On the basis of and manner sta	examinat	wledge, death ion and/or inv	occurred at the tile restigation, in my o	me, date and popinion, death	place, and due to the ca occurred at the time, da	use(s) and manner te and place, and c	as stated. lue to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier				29c. Licens	se number	29	d. Date signed (Mo	onth, Day, Year)
	r s ⊢ ō			45	2		0	5232	-3	05-12-	-2008
			30. Name and address of person who comp	leted cause of de	eath (Item	23a) (Type.					
7	2-/		Dr. Murshed, 1126					ryland	21742		
İ	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 3 20	32. Registre			1-20				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a I per me, 2880, 06/04/08dhb

Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** APRIC 2008 PHILIP 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner KEN 7 HasPITAL CENTER If Under 1 Year | If Under 24 Hrs TERTOWN HESTER RIVER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1☐M 2☐F 186-22-3674 84 Director 5-15-23 PENNSYLVANIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes 2 ☐ No Director Maryland Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 2500 Lambs Meadow Road 21678 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iter any injury or other traumatic event the Madical or item. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No white 3altimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Work Food & Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Ivan Huff, Sr. Harriet Julia Geist 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Schauber Road Chestertown, MD 21620

Date Date 20c. Location - City or Town, State Craig Gibson/ Case Manager 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Chesapeake Cremation Cntr. 5/1 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keik of Fellows, Helfenbein, & Newnam Funeral Home PA 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CARBIO PULLUNANS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Afreil Стичие Sequentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to for as a consequence of Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown Right Hop And Fuleraal Fixa Fran 1 Tyes Completed O Steopers 1/1 Slowy of Ser zine Bosarder 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No Demention 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation T Natural 1:30 aM 04/11/2008 1 ☐ Yes 2 ☐ No Subject slipped and fell. death. 2 Accident or Attendate death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hone 28f. Location (Street and Number or Rural Route of City or Town, State) 2500 Lambs or Rural Route Number, 4 ☐ Homicide Meadow Rd., Worton, MD To the Hospital within 24 hours al 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 2388 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. ARRAISALTA. U.D. 223 Hogh Street, CHETHERTOWN Wed 21620.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2. Registrar's Signature

			For State Registrar		State of	Marylan		artment ertificate			Mental Hy	giene Reg. No.	71111	8	15905
	Physici	an	1. Decedent's Nam								2. Date of De	eath Day	/ Ye	ear	3. Time of Death
1	/Medic	cal			tchinson						5	3	0		11:30PM
	Examin	ier	4a. Facility Name (	i hospi		altinio	re		wn, or Loca Utuno	tion of Death		4c.	County of I	Jeath	
	Funeral		5. Social Security N			Age (In yrs. I		) If Under 1	Year If U	nder 24 Hrs/	8. Date of Bir	rth ,	9.	Birthp	ace (State or Foreign
	Director		547-54-1	.630	1 □ M 2 □ <b>X</b> F	67	Yrs.	Months [	Days Ho	ours Min.V	8. Date of Bir Oct 26	<sup>a</sup> 1940	)	Coun	CA
	and w		Usual Residence of 10a. State	f Decedent 10b. County		10c Cib	, Town or L	ocation						10	Od. Inside City Limits
	Aaryla f sho	ō		Carro	11	100. 019	Taney							'	1 □XTes 2 □ No
	the Maryland r 28a-f show	Director	MD 10e. Street and Nu		1-1-		raney	10f. Zip C	ode			10g. Citi	izen of Wha	t Coun	trv?
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	ems ems	Funeral	11. Marital Status		12. Was Deced	ent Ever in U.S	5. 13.	. Was Deceder	nt of Hispan	ic Origin? (Sp	pecify Yes or No Rican, etc.)	0-	14. Race - Black, V		
36	or it	by Fu		ied 2 Married	1 ☐ Yes 2 If Yes, Give	. <b>⊡</b> No		1 ☐ Yes 2 월		ecify:	/ Tiloun, 010.)		Specify:		ite
30	hours tural	q pa	3 Widowed	4 ☐ Divorced  15. Decedent's E	Year or Date	es:	16a Dec	edent's Usual (	Occupation			16h Ki	ind of Busin		
75	nin 72 e. In "nat	plet	(Spec	cify only highest g	rade completed)	lar E . )	(Give	e kind of work of DO NOT use	done during retired)	most of work	ing	TOD. KI			•
Rebekah d 21215-00	d within giene. er than "	Completed	Elementary/Seco	ondary (0-12)	College (1-4	юг 5+)	Orga	nist/C	hoir I	Directo	or		Chw	che	es
مع ک	be filed tal Hygi d other event,	Be (	17. Father's Name		t)				- 1		e (First, Middle	, Maiden	Surname)		
<u>₹</u>	should be tand Mental smarked oumatic eve	ပ္	A.D. Mah	<del>-</del>							Carnes				
Hutchisson Rebekah altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the "edical Expriner must be once.	- 12	19a. Informant's Na Thomas H		(Type. Print) n/husband	đ	19b. Mail 222	ing Address (S Clubs:	ide D	lumber or Ruj	ral Route Numb Paneyto	er, City o WN ,	MD 2t	ľ <b>7</b> 87	Code)
ore	ges 1 & t of He If item or oth		20a. Method of Disp		☐Removal from St	1 0	amotory cre	osition (Name ematory or othe	ar nlaca)		Date		cation - Cit	,	
∄ Ë	t. Pag rtmen rtant; rjury	- 4	4 ☐ Donation	5 ☐Other (Spec	ify)	Bri		nurch C		1		100	Windso		ענויז
Bal	permit. Departr Importa any inju		21. Signature of Fu	uneral Service lice	nsee		2				me and ( ad Wes				21157
			23a. Part 1. Enter t shock, or hea	the disease, or con	nplications that cau	used the death	. Do not er	nter the mode of	of dying, su	ch as cardiac	or respiratory a	arrest,			Approximate Interval Between
	Physician	i ii	Immediate Cause disease or condition	(Final on	_ a.	Conges	twe	react	failer	è					Onset and Death
	/Medical Examiner		resulting in death)	•	Due to (or	ras a c insequ	ence of):		9					15	3 Days
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	ertific ding p	Mec	IF FEMALE:		00. 1/									-	
Вох	eath certificate be executed attending physician and for use as the burial-transit	Physician/M	23b. Was decedent in the past 12	months?		ome of pregna th 2□ Fetal .nt at time of d	death 3	☐ Ectopic preg	gnancy			1	23d. Date o Month		ry Day Year
0	at the de by the tached	ysic	1 ☐ Yes 2 € 9 ☐ Unknown		9 Unknov		saur 5	□ Other (spec	пу)						
σ.	res that signed b be deta	by Pt	Part II. Other signif	ficant conditions	contributing to deal	th but not resu	Iting in the i	underlying caus	se given in I	Part I.	23e. Did	tobacco u	ise contribu	te to th	e cause of death?
ğ	w require been sig should be										1 🗆	Yes 2	No 3[	Prob	ably 4 ☐ Unknown
Division of Vital Records,	law re as be 2 sho	Completed									24a. Was		24b. Wer	e autop	psy findings available
- E	Physician: The law this certificate has al director, page 2	E S									auto perfo 1 □ Yes	ormed?	dea	th?	npletion of cause of
/ita	cian: sertific setor,	Be (	25. Was case referrexaminer?	4						Place of Deat	h (Check only o				
of	Phys this c	은	1 ☐ Yes 2 ☐ 27. Manper of Deat			patient 2 1	ER/Outpatie				ome 5 🗆 Resi			Specify	)
on	ding Ph h. After thi funeral o	tion	1 Natural	5 ☐ Pending investigation		Day, Year)	Injury	of 28c	. Injury at Work? 1 □ Yes		28d. Describe	how injur	y occurred		
i <u>s</u>	Attendi	fica	2 ☐ Accident 3 ☐ Suicide	6 Could not be	28e. Place of	l Injury - At ho	me, farm, st	reet, factory, of		-	28f. Location (	Street an	d Number o	r Rurai	Route Number,
Ö	s after	Certification:	4  Homicide	determinet	building	, etc.*(Specify	)				City or To	wn, State,	)		,
	Hospi 4 hou Funer tely fil	Medical	29a. Certifier (Check only one)	f Certifying P 2 Medical Exa	hysician: To the be miner: On the bas and manne	is of examinat	vledge, dea ion and/or i	th occurred at nvestigation, in	the time, da my opinior	ate and place, n, death occur	and due to the	cause(s) date and	) and mann I place, and	er as st due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and	title of centifier	and manne			29c. L	icense num	ber	Т		te signed (A		
	WIL			brenty	the MA			F	RES -	000		Ma	43,	200	08
	10	f	30. Name and address			of death (Item		, Print)	2401 V	1. Belv Balli	edere A	Ave.,	Balt	imo	re, MD 21215
	Stat		31. Date filed (Mont	th, Day, Year)	) 32. Reg	iar's Signat	ure .		0	Sunci	,				<u></u>
	Registra	ar		MAY 0 6	2008	Roller	15.	Marke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03602 James Glover Holden State of Maryland / Department of Health and Mental Hygiene 2008 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Time of Death Physician/ Month Day May 11, 2008 James Glover Holden 0905 hrs Medical Examine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's 6125 Central Avenue Capitol Heights If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. Appendix 1.005 Foreign North 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Director 577 44 5938 73 April 5, 1935 CountryCarolina 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10b Count 10c. City, Town or Location 1 Yes 2xx No Maryland Prince George's Brentwood Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3701 Quincy Street 20722 United States Funeral 14. Race - American Indian, Black, 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 X Yes 4 XXDivorced 1 Yes 2 X No specify: 3 Widowed If Yes. Give Year Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than Painter Contractor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Buris Holden Bertha Radford or other traumatic event, Be 19a. Informant's Name/Relationship (Type, Print) (Friend)
Steven Postanonicz, III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2469 Yarmouth Court, Waldorf, MD 20602 20a, Method of Disposition

1 XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Cedar Hill Cemetery May 22, 2008 Suitland, MD Donation 5 Other Specify 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21, Signature of Funeral Service Licensee Alexandira Ferry Road, Clinton, MD 20735 Approximate Interval 23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertenive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed the attending physician and ed for use as the burial - transi Physician/Medical X UNPENDED #23a.PII.27.perME G879 5/27/08 TI IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Chronic alcoholism Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other, Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work' 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 X Natural 5 Pending Yes 2 No Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physiciary: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 12, 2008 O.C.M.E. s of person who completed cause of death (Item 23a) 30. Name and addi Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. 31. Date filed (Month, Day, Year) . Registrar's Signature 3 2 Registra

Physician /Medical Examiner
-

Director

the Maryland ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev is marked

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

and attending physician for use as the buria To the Hospital or within 24 hours at To the Funeral D

Division or Vital Records, P.O. Box 68760

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 5:01 Helsle-Ann MAY 2008 Nancy 16 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Hagerstown Washington Washington county Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 29, 19 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In yrs. last birthday) Days Hours 215 20 7574 83 1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes XXNo WV Morgan Berkeley Springs Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25411 160 Douglas Lane U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: White Completed by 3€Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Clay Grove Naomi Virginia Michael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21518 Jefferson Blvd., Smithsburg, MD 21783 Glenda G. Tapley 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory 5/20/08 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. 21. Signature of Funeral Service Licensee M00522 95 Union St., Berkeley Springs, WV 25411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxemia Hours disease or condition resulting in death) Due to (or as a consequence of) Hours Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Perforated Diverticulitis Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Acute renal failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Septic abdomen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Perforated Liverticulities Ventilator dependence 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46081 May mD 16,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Collins, MD, 11110 Medical Campus Road, Suite 242, Hagerstown, MD 21742 31. Date filed (Month, Day, Year) Registrar's Signature MAY 2 3 2008 Registrar

DHMH 17 Rev 1/2001

			partment of Health and Mertificate of Death	lental Hygier	2000 10000
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physici /Medic		Stella Mae Juergens		May 1	Pay 2008 8:30 AM
Examin		4a. Feetlity Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under Year If Under 2 Hrs.	9. Date of Righ	HARTURS
Funeral Director		229–12–6181 1 M 2 F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 8/10/1925	ar) 9. Birthplace (State or Foreign Country) Virginia
g		Usuel Residence of Decedent		0/10/1525	Viiginia
anylan	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
he Mi	Director	MD Harford Havre de	<del></del>		1 Tyyes 2 No
1715-6036  within 72 hours after death with the Maryland ane. then "naturel", or iteme 23a or 28a-f ehow the Mudical Examinar must be notified at		10e. Street and Number 839 Juniata Street	10f. Zip Code	10g.	Citizen of What Country?
seath me 23	Funeral		21078  3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A.  14. Race - American Indian,
or iter		1 Never Married 3 Amed Forces? 1 Yes, Give	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
ours a	1 by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐xNo Specify:		Specify: White
72 h	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	ing 16b	. Kind of Business/Industry
within then	дшо	Etementary/Secondary (0-12) College (1-4or 5+)	ager		othing store
Hygi other	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maio	
Iryland 21215-0036 should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "naturel", or items 23a or 28a-1 ehow imatic event, the Medical Examinal must be notified at	To B	John Barnes	UNE	ζ	
0 2 8 9 9		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Run	al Route Number, Cit	y or Town, State, Zip Code)
				re de Grac	
0 0		i Countai 2xxxioni attori o Charlovat notti otate 1	ematory or other place)		Location - City or Town, State
timentant:			erris & Co. 5/20		st Chester, PA
Baltimo		21. Signature of commencer visa License	22. Name and Address of Facility Tarring-Cargo Fur	neral Home	P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	Aberdeen, Marylar inter the mode of dying, such as cardiac		Approximate
Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	120 midoux Xx		Interval Between Onset and Death
/Medical		disease or condition resulting in death)  Due to for as a consequence of):	JAEN MON CIOL	)	
Examiner		Sometiment of Connection	the Keart For	lino	y pay
ש פילו	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(24	1
and I-trans	Examin	Cause (Disease or injury that inflated events c. resulting in death) Last Due to (or as a consequence of):	ornia.		10 0 mm
death certificate be executed e attending physicien and of for use as the burial-transit	Ical E	500 (0) 43 2 0013844 (0).			I
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BOX 68 leath certific attending pl	M/M	IF FEMALE: 23b. Was decedent pregnant 23c. tf yes, outcome of pregnancy	O Estable programme		23d. Date of delivery
o death	Physician/Med	1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month Day Year
Hecords, P.O. The law requires that the di the has been signed by the bage 2 should be detached	Phy	9 🗆 Onknown		1	
	2	Part II. Other significant conditions contributing to death but not resulting in the	1	4	to use contribute to the cause of death?
VITAI HECOTGS, itian: The law requires t certificate has been signe rector, page 2 should be o	Completed		hru varilar accid		2\QNo 3 Probably 4 Unknown
NY VITAI MEC hysicien: The law his certificete has t	d L	D+menta		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	ပို	25. Was case referred to medical		1 ☐ Yes 2 🕡	
/sicie	ToB	examiner?  1 Yes 20800 Hospital: 1 Inpatient 2 ER/Outpat	Othor	h Check only one	6 ☐Other (Specify)
g Phys g Phys ter this serat di		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in	
r Attending F r Attending F er death. rector: After i by the funera	atlo	2 Accident investigation	M 1 Yes 2 No		
DIVISION OF all or Attending Phy after death. I Director: After this d in by the funeral d	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
DIVISION Of VITA Hospitel or Attending Physician: 4 hours after death. Funerel Director: After this certificately filled in by the funeral director.		20.0.11			
DIN To the Hospitel or a within 24 hours after To the Funerel Dire completely filled in b	Medical	29a. Certifier	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause red at the time, date a	o(s) and manner as stated.  and place, and due to the cause(s)
within 2 To the complet	Me	29b, Signatore and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		W (L/Mllu mn	127975	- 5	119/02
7		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	. 0 0	
1		ATUN McClure GIT M	alpail Ild 19.	ek Hin	ND. 21014
Sta Registra		31. Date filed (Month, Day, Year) MAY 2 3 2008  32 Aegistrar's Signature	parti	·	

			Please	Type or Print in				•		_	
			For State Registrar	State of Maryla		ertificate d		id Mental F			
			Registrar     Decedent's Name (First, Middle, Las	t)		Timeate	Dealli	2. Date of	Reg. No Death	<u>~2008</u>	3. Time of Death
	Physici /Medi		Ethelett M. Jon			T				008	5:15 A M
	Éxamir	ner "	4a. Facility Name (If not institution, give		ı		n, or Location of [	Death		County of Deat	
	Funeral		Washington Adven 5. Social Security Number 6. Se		L s. last birthday	Takoma		Hrs. 8. Date of	Birth	ontgomer	- <b>y</b> hplace (State or Foreign
н	Funeral Director			□ M 2□ <b>X</b> F 83	Yrs.	Months Da	ys Hours	Min. (Month, 3/2/	Day, Year,	)   Co	untry) Vork
	PL .		Usual Residence of Decedent					3,2,			
	arylar show d at	_	10a. State 10b. County		City, Town or L	ocation.					10d. Inside City Limits 1X Yes 2 □ No
	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Funeral Director	MD Prince G	eorge's Hy	attsvi						
	vith th	Dire	10e. Street and Number			10f. Zip Cod				tizen of What Co	ountry?
	s 23e	iral	5602 Decatur Plac		11.0	2078		0.40	US	A 14. Race - Ame	vices Indian
	item item ner n	ığ.	11. Marital Status  1 ☐ Never Married 2☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No	0.5.	If Yes, specify (	of Hispanic Ongir Cuban, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	Black, Whit	
36	rs aft <b>I', or</b> <b>xami</b>	by F	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2💢	No Specify:			Specify: B1	Lack
215-0036	2 hou atura cal E	ed	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Oc	cupation		16b. k	(ind of Business/	/Industry
215	hin 7; In "n Medi	ple	(Specify only highest gra	de completed) College (1-4or 5+)	(Giv.	e kind of work do DO NOT use re	ne during most o tired)	f working			
21	d with	Completed	9th		Menta	1 Health	Therap	ist Asst	. Ro	chester	Psychiatric
	al Hy al Hy i othe	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Mid	ldle, Maidei	n Surname)	
<u> </u>	Ment Ment arkec	2	Samuel Jones				Bessi	e Wells			
Maryland	2 sho and is mi		19a. Informant's Name/Relationship (7					or Rural Route Nu		, ,	,
	and ealth m 27		Gwendolyn S. Turn					Hyattsv			
O.C.	ges 1 t of H If Ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery, cr	oosition (Name or ematory or other		Date	20c. L	ocation - City or	Town, State
Ë	tmen tant:		4 ☐ Donation → 5 ☐ Other (Specif)	) Me		itan Cre	-III e	10/2008		xandria,	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service Licen	see				Marshall			
			23a. Part. Enter the disease, or com	alications that caused the de		-		Washing		DC 20011	Approximate
	المتداع		shock, or heart failure. List only	one cause on each line.	aui. Do not ei	nter the mode of	dying, such as co	ardiac or respirato	ry arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Urinary Ti		fection					
	Examiner			Due to (or as a cons		II1	4.5				
Ь	- <del> </del>	ē	Sequentially list conditions,	b. Infected I		us orce	rs				
	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<sub>c</sub> Hypoxia							
ó	executed an and rial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
9289	eath certificate be eath certificate be eath attending physiciar for use as the buri	by Physician/Medical		d. Failure to	Thriv	e					
39	ng ph as th	Med	IF FEMALE:	20							
Box	death ce e attendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	□Ectopic pregn				23d. Date of de Month	livery Day Year
	0 0 D	/sic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify	/)		_	WOM	Day Tour
P.0	requires that the de sen signed by the a rould be detached fo	Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the	underlying cause	e given in Part I.	23e. [	Did tobacco	use contribute to	o the cause of death?
Records,	signe d be		<b>3</b>		<b>3</b>	,	<b>3</b>			2 □ No 3 □ P	
Ö	ned Seen	Completed						_		T	Α.
Rec	The law ate has b	ם						<u> —</u>	Vas an lutopsy performed?	prior to death?	utopsy findings available completion of cause of
<u>_</u>	n: Th ficate r, pag		05 M/					1□ Y	es 2X∏N		s 2□No
Vital	rding Phystclan: The law h. : After this certificate has b funeral director, page 2 s	Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:	TER/Out#	00000	Other:	f Death (Check or			
ō	Phy er this eral d	To	27. Manner of Death	28a. Date of Injury	ER/Outpatie		4 🗆 Nurs	ing Home 5 ☐ F 28d. Descr		6 ∐Other (Spe ury occurred	ecity)
on	Attending r death. ector: After by the fune	tio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year,			Injury at Work? 1 ∐ Yes 2 ∐ No	j	,	-	
Division	Attendir death.	ifica	3 Suicide 6 Could not be 4 Homicide determined		home, farm, s	street, factory, of	lice				ural Route Number,
Ö	s afte	Certification:	4 Dirioniidae	building, etc. (Spe	cony)			City of	Town, Sta	(e)	
	ne Hospital or Attendi n 24 hours after death. ne Funeral Director: A pletely filled in by the fo	edical (	29a. Certifier (Check only 2 Medical Exam	ysician: To the best of my l	knowledge, dea	ath occurred at th	ne time, date and	place, and due to	the cause(	s) and manner a	s stated.
	ne H ne F ne F	ğ	one)	and manner stated.		vooagaaon, m	y opinion, ueatt	, socurred at the t	o, uate al	piace, and du	c to the cause(s)

State

Padma Chirumamilla 31. Date filed (Month, Day, Year) MAY 0 9 2008

29b. Signature and title of certifier

7600 Carroll Avenue, Takoma Park, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

MD

063839

20912

			1 - For State Registrar	State of Marylar	nd / Depa	artment o	of Health and I	Mental Hy	•	8 16911
	Physici	an	1. Decedent's Name (First, Middle, La Lewis	James		Sr.		2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic	al						May	04, 2008	5:30 p M
	Examin	er	4a. Facility Name (If not institution, giver Clinton Nursing a		or	Clint	m, or Location of Death	1	4c. County of	Georges
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Y	ear   If Under 24 Hrs.	8. Date of Birt		Birthplace (State or Foreign Country)
	Director		250-44-3493	M 2□F 78	Yrs.	Months Da	ays Hours Min.	Decembe	er 28 C	olumbia, S.C.
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	ξ	MD Prince	Georges Fo	restvi	.11e				1 ¥ Yes 2 No
	r 28a	lrec	10e. Street and Number			10f. Zip Coo	de		10g. Citizen of Wha	at Country?
	23a c	Funeral Director	8007 Boundary Dr.				20747		USA	•
	er des Items	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black, 1	American Indian, White, etc.
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ★ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>½</b>	No Specify:		Specify:	Black
Ö	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual O	ccupation	tina	16b. Kind of Busin	ness/Industry
21	ithin 7 ne. Med "r	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	•	Killig	<b>5</b> 4 .	
2	iled w lygier her th		11th 17. Father's Name (First, Middle, Last		Met	ro Bus		no /First Middle	Privat  Maiden Sumame)	e
anc	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examination to notified at	o Be	Unknown				Vivian			
Maryland 21215-0036	s 1 and 2 should if Health and Men item 27 is marke other traumatic	To	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (St	reet and Number or Ru			ate, Zip Code)
	1 and 2 Health a tem 27 is		Lewis James Jr./	Son	800	7 Bound	lary Dr. Fo	restvil	le,MD 207	47
Baltimore,	of Health of Health if item 27 or other tr		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	Domouni from State	cemetery, crei	sition (Name of matory or other	place)	Date	20c. Location - Cit	
Ě	ment of tant: if it		`4 ☐ Donation 5 ☐ Other (Specif	y) KI		e Park		13/2008		le, Maryland
Ba	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Lice	Chertin		716 Ker	nedy St. N	W, Wash	ington, D	Funeral Home C 20011
	Pnysician		23a. Part1. Enter the disease, or own shock, or heart failure. List chly Immediate Cause (Final disease or condition	plications that caused the deat one cause on each line. Prosta			dying, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec						
	Lammer	100	Sequentially list conditions,	b. Due to (or as a conseq	mence of).					
	uted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Classes or injury	540 (0) 43 4 05/1300	adrice or,					
o	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
3760,	ate be nysicia he bur	Ical		d						
39 20 20 20 20 20 20 20 20 20 20 20 20 20	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:							
Box	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Feta	ıl death 3□	Ectopic pregn Other (specify			23d. Date of Month	,
o.	t the de by the a	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	36	_ Other (apacis)	//			
a.	es that igned b	by Pł	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause	e given in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
ecords,	w require been sig should b							1 🗆 Y	Yes 2. No 3.	Probably 4 Unknown
ecc	as be	Completed						24a. Was	osy prio	re autopsy findings available or to completion of cause of
X		Соп							rmed? dea 2 ☑ No 1 □	th? Yes 2□ No
Vital	nysician: The law nis certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			Other	th (Check only o		
ō	Physic this stal di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		4 ₩ Nursing H Injury at Work?		dence 6 Other one of the following occurred	(Specify)
0	nding f tth. :: After e funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Work? 1 ☐ Yes 2 ☐ No			
Division	if or Attending Physician: after death. I Director: After this certific d in by the funeral director,	Certification;	3 Suicide 6 Could not b	e 28e. Place of Injury - At h building, etc. (Specia	ome, farm, str fy)	reet, factory, off	fice	28f. Location (5 City or Tox		or Rural Route Number,
	pital c		20a Caddiar 45 Caddia					mand place at the		
	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by	Medical	29a. Certifier 1 ★ Certifying Pt (Check only 2 ★ Medical Examone)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deat ation and/or in	h occurred at the vestigation, in r	ne time, date and place my opinion, death occu	red at the time,	date and place, and	er as stated.  I due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	)			cense number		29d. Date signed (/	- '
	(11		Will-	James A		D	35206		May 4	, 2008
(	()/so		30. Name and address of person who				01 74 77	_1_4	. WD 007	1. 1.
	Sta	10	Dr. William Tanno	er 11701 Livi 32. Registrar's Sign		Kd. #1	UI, Ft. Wa	sningtor	1, MD 207	44
	Registr		MAY 1 2 2008	som to	see!					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 60 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Katherine S. Katsouros 11:15 pM 2008 /Medical May 7, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery General Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days Hours 1 ☐ M 2 🖫 F Months Director 1927 577-40-6989 5, Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County fshow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examinations to struited at Director Silver Spring 1 ☐ Yes 2 ▼No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15100 Interlachen Drive, 20906 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Head Bank Teller Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steve Nicholas Katsouros Mary S. Averinos ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3683 S. Leisure World Blvd. Silver Spring, MD 20 06 Louis Katsouros/Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State Mav Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signatural f Funeral Service Licena Francis J. Collins Funeral Home Inc. 500 University Blvd, . W, Silver Spring, MD 20901 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 🐧 2 No 1 ☐ Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After th funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1: Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 🖺 Accident Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

Box 68760, P.0. Records, Vital o Division Hospital or Attending

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29a. Certifier (Check only

State Registrar

31. Date filed (Month 2008

29b. Signature and title of certifier.

30. The and address of person who completed cause of death (Item 23a) (Type, Print) STO ADEWUNMI, 0 MD WONT GOMEN) Registrar's Signature

sawant Mz, MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year SARAH KNOPE GERTRUDIZ 9,304 5 2008 al 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard County General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. Fast birthday Howard Columbia If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. 1 ☐ M 2 ☐ F 5/10/1927 174-22-3834 PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Clarksville Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21029 USA 6505 Ballymore Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ALE No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drilling Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robinson Gertrude Philip Wuenstel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6505 Ballymore Lane, Clarksville, Md. 21029 William Ρ. Knopf 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/9/2008 | Carnegie, Pa. **ChartiersCemetery** 22. Name and Address of Facility Hershberger-Stover Inc.F.H. 21. Signature of Funeral Service Ligense mo1035 Crafton, Pa. 15205 170 Noble Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pireumonia Due o (or as a consequence of): espirator Sequentially list conditions Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD Due to (or as a consequence of) Forilure eenal

**Physician** /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

ģ

Be Completed

2

Examine To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or use as the hurial-transit by Physician/Medical Be Completed Medical Certification: To

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknowh	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery  Month Day Year
Part II. Other significant conditio	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Dem	entia	24a. Was an autopsy performed?  1 ☐ Yes No 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 2 ☐
25. Was case referred to medical		th (Check only one)
examiner?	Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Injury  28c. Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could n 4 Homicide determi		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only 2 Medical	Physician: To the best of my knowledge, death occurred at the time, date and place xaminer: On the basis of examination and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

KENDRA 31. Date filed (Month, Day, Year)

MAY 1 A.

1 Cenda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2225 MS 32. Redistrar's Signature

29c. License number

D0062545

Cedan Un, Columbia

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Betty Pritchett Lewis LeCompte 12:15 p<sup>M</sup> May 18, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester 8. Date of Birth (Month, Day, Year) 1962 Church Creek Rd. Cambridge If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1931 Maryland 1□ M 2 F Yrs. 76 215.26.4368 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland Dorchester Cambridge 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21613 USA 1962 Church Creek Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: à 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Telephone Telephone Operator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhodella Helen Bramble James Morgan Pritchett ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1966 Church Creek Rd., Cambridge, MD 21613 Jody L. LeCompte/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 5.21.2008 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21/ M nature of Funeral Service Licensee <sup>22, Name and Address of Facility</sup>
Curran-Bromwell Funeral Home, P.A.
308 High St., Cambridge, MD 21613 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 3a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) Pulmonory Severe Physician /Medical Due to (or as a consequence of): Examiner REVINC Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (If as a consequence of) Examiner ulor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Matural 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D47924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CAMBRIDGE BYRN ST 503 NOMAN TMNWY 31. Date filed (Month, Day, Year) MAY 23 2008 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

16b. Kind of Business/Industry Department of Justice 18. Mother's Name (First, Middle, Maiden Surname) Katherine Goeghan

Day

2008

Montgomery

4c. County of Death

10g. Citizen of What Country?

United States

Black, White, etc.

Specify: White

7:05 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 X No

Cornelius Joseph Leary 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Watkins Pond Blvd. #206 Rockville, MD 20850

Claire R. Leary (Wife) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 2 Other (Specify) Intombment

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gate of Heaven 2008

Silver Spring, MD

21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Myocardial Infarction

Cardiopulmonary Arrest

Due to (or as a consequence of)

Due to (or as a consequence of):

23b. Was decedent pregnant

**Physician** /Medical

**Examiner** 

sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

ģ

Completed

Be

P

in the past 12 months? 1 ☐ Yes 2 ☐ No

Diabetes Mellitus

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal dea 2 Fetal death 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown

Year

Approximate Interval Between Onset and Death Minutes

Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes

1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

(Check only

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

PUD64860 May 6th

Type, Print)

Medical Center Drive, Rudwille, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

State Registrar

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

within 24 hours a To the Funeral C

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State 4a & 26, 5/14/08, M.S. Kent Certificate of Death Amend Item 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05/10/2008 04:30A MARY CLAIRE LITTLE /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bennett-Little House KENT 1002 TWIN CT. CHESTERTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 1 X F Director 1/10/1955 MD 044-62-4197 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 □ Yes 2 □ No Director KENT WORTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12331 WOODS RD. 21678 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a isy or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL EDUCATION STUDENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORMAN A. LITTLE ROSEMARY WANGER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY W. LITTLE/MOTHER 12331 WOODS RD. WORTON, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2008 GALENA CEMETERY GALENA, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee a. Int. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Inset and Death Immediate Cause (Final **Physician** /Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Dementa Exami physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 10 in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No has 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dottle Reprett-Little 1 Yes 2 No To the Hospira. ...

- within 24 hours after death.

To the Funeral Director: After this c 1 | Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertifie

Registrar

DHMH 17 Rev 1/2001

State

Frederick

31. Date filed (Month, Day, Year)

ms

6602

32. Registrar's Signature

Church Hill Rol. Chestertown, MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Delbou

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 05 Day **Physician** 20ඊ්දී 2:25 pm Irene Virginia Larrimore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Manchester Longview Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** August, 30 1 □ M 2 🖫 F Months 1915 W.VA 92 220-01-7116 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 No **Funeral Director** Lutherville MD Baltimore 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21093 37 Cinder Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **2** No 1 ☐ Yes 2 No Specify. Specify: White Completed by ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Hacker Omar Yerkey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lutherville, MD 21093 Thomas Larrimore III/son 37 Cinder Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 05/09/2008 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Greenbackville Methodist Ch Cem | Greenbackville, VA 21. Signature of Funeral Service Licenses Prints Attimetativ Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rebrovar /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner fran, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for the control to the funeral director. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 21410 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital

P.O. Box 68760,

Records,

Baltimore, Maryland 21215-0036

WJZ

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

gest, Manchester,

21102

who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAY 08 2008

29b. Signature and title of certifie

29a. Certifier

Medical

State

Registrar

and manner stated.

08-03726 Robe

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 69 | 8

Robert G. Marshal		St For State	ate of Ivia	iryianu / L	Certific	cate of	Death	and		, 5	Reg	, No.		
Physician	Re	gistrar Decedent's Name (First, Midd	lle,Last)							2. D	eate of Death Month I lay 16, 20	Day Yea		Time of Death 0035 hrs
Me I Examine	er	Robert (	G. Marsha			1 41	b. City, Tov	um or Lo	cation of [	Death M	ay 16, 200	4c. County of	of Death	
	48	Prince Georges Hosp	on, give street a	ind number)		40	Chever		Cation of E			Prince G		
	_	Social Security Number	6. Sex	7. Age (I	n yrs. last bi	irthday)	If Under		If Under 2			(MM/DD/YYYY	9. Birth	ashington, D.
Funeral Director	- 1		1×M 2		44	Yrs.	Months	Days	Hours	Min.	ugust 1	6, 1963	Coun	
Bilector		577–88–0188 sual Residence of Decedent	I X WI Z											Od. Inside City Limits
any	1	Da. State 10b. County	(C	1	c. City, Tow	vn or Location	on	Oxon	Hill					1 Yes 2 No
show show	۱ ام		George's	·			10f. Zip C				10	g. Citizen of W	hat Count	ry?
Maryla	Director	0e. Street and Number	O				101. 210 0		20745			U.S.A.		
h the 13a or		1508 Deep Gorg	e Court	as Decedent E	ver in U.S.	13, Wa	s Deceden	t of Hisp	anic Origin	n? ( Speci	fy Yes or No-		e - Americ te, etc.	an Indian, Black,
tth wit	<b>T</b>	Marital Status     Never Married 2		med Forces?_	No	If Y	es, specify	Cuban,	Mexican, I	Puerto Rio	can, etc.)	*****	Black	<i>c</i>
ter dea			Divorced If Yes, C	Give Yeer			Yes 2∑				l. deno	Specify:		
urs afi ttural	₹  -	15. Decedent's Education (S	pecify only high	est grade comp		Sa. Deceder during m	nt's Usual C nost of work	Occupations of the contract of	on (Give ki DO NOT u	and of work use retired	k gone	TOB. National		,
6 72 hc	흥	Elementary/Secondary (0-1	-,	llege (1-4 or 54	-)	Courie	er					Laser	Courie	er Service
5-0036 iled within 77 Hygiene. d other than	Completed	12th grade 17. Father's Name (First, Midd						1	8. Mother's	s Name (F	irst, Middle, I	Maiden Surnam	ne)	-
215-1 be filed nital Hyg rked off	Be C	Robert	Grady Ma	rshall,								se Ayers	wm State	Zin Code)
212 ould be Ment; mark	의	19a. Informant's Name/Relation	onship (Type, Pr	rint )		19b. Mailin	ng Address	(Street	and Num	nberorRui Oxoon H	iill, Ma	nber, City or To ryland 2	20745	, Zip 6646)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Inter of Health and Mental Hygiene with "natural", or items 23a or 28a-f sho wit. If item 27 is marked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once		Ms Venus Y. Asht	on (Siste	er)	20h Pla	ce of Dispo	sition (Nan	ne of cer			Date	20c. Locatio	n - City or	Town, State
re, s I and f Heal If iten		20a. Method of Disposition 1 Burial 2 Crema	tion 3 Re	moval from Sta	cre	matory or o	ther place)	)		May 2	23, 2008	Clinto	n, Mar	yl <i>a</i> nd
imo Page ment c tant: or oth		4 Donation 5 Other	Specify:		Resul		Name and		of Facility			neral Ho		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	21 Signatura of Funeral Serv		OMBINETY !		1,0		. 131	N	ינו יוו	whinoto	n D.C.	20019	Approximate Interv
Physician	$\dashv$	236. Part I Enter the disease	, or complicatio	ns that caused	the death. D	o not enter	the mode	of dying,	such as c	ardiac or	respiratory ar	rest, shock, or	heart	Between Onset an
¶ ** Nedical	1	failure. List only one ca	ase a Gun	shot wound	to back									Dodan
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wound to back  Due to (or as a consequence of):											<u> </u>	
	<u>.</u>	Sequentially list conditions,	b Due t	o (or as a conse	equence of):									
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
D. 5 . 12	zar	events resulting in death) La	ast Due to	o (or as a cons	equence or).									
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30, te be exe yssician i	sician/Medical	IF FFMALE:	23	Bc. If yes, outco	me of pregn	ancy			[]euti		201	23d. Dat Mont	a of delive	ry Day Year
3876 rtifical ling ph	an	23b. Was decadent pregnant past 12 months?	in the	Live birth	t time of dea		Fetal death Other (Sp		Ectop	oic pregna	ncy			,
Box 68760, re death certificate be the attending physic hed for use as the bur	Sici	1 Yes 2 No 9	Unknown 9	Unknown										to the cause of death?
O. B. Charthe de that the de detached detached	Phy	Part II. Other significant co	onditions con	tributing to dea	th but not re	sulting in th	e underlyir	ng cause	given in F	Part I.				obably 4 Unknow
Cords, P.O. It law requires that the has been signed by the 2 should be detache	<u>\$</u>										24a. W		4h Were	autopsy findings availa
rds, requir	Completed										au	topsy rformed?	pnor to death	o completion of cause
ecol ne law te has	) E											s 2 No	1 🗸	Yes 2 No
L R m: Tl striffca stor, pa	Se C			11-1-				1	oe of Dea	th (Check	only one) ng Home 5	Residence	6 Ot	her:
of Vital Recoling Physician: The law After this certificate has huneral director, page 2.8	0 0	1 ✔ Yes 2 No	Hosp		ient 2	ER/Outpati 28b. Time		DOA 28c. Ir	njury at Wo		28d. Descri	be how injury o		
I Of ing PI After funera	l i	27. Manner of Death  1 Natural 5	Pending	28a. Date of Ir (Month, Day May 15, 200	(Year)	2356 hrs			Yes 2		Subject s			
Sion tttend death. ctor:	atic	2 Accident	Investigation	28e. Place of	Injury - At h	ome, farm,	street, facto	ory, offic	e building,	etc.	28f. Locatio	on (Street and I	Number or	Rural Route Number,
Division of Vital Records, tal or Attending Physician: The law requirant and the death.  An Director: After this certificate has been 8 led in by the funeral director, page 2 should?	Certification:	3 Suicide 6	Could not be determined	(Specify) H	allway of	apt. con	nplex					n, State) Place Apt. #		
E 8 5 5	ع ا		ing Physician:					the time	date and	place, an	d due to the	cause(s) and m	anner as s	stated. o the cause(s)
To the Hos within 24 h	dica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and											(Month, Day, Year)	
To		29b. Signature and title of certifier  29b. Signature and title of certifier  O.C.M.E.  May 16, 20												
		melle	Tes	nix					J.IVI. ⊑.					
_		30. Name and address of	person who con	npieted cause o sistant Med	of death (Iter	m 23a) niner '	111 Pen	n Stree	et, Baltiı	more, N	1D 21201			
		Tasha Greenberg		4%	trar's Signa		mile	_						
	Stat		2 3 2008	8 Liles	100	J. 19	A STATE OF							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician May 16, 2008 1337 Morgan Charlotte М. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Allegany County Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 9, 1927 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 F МĎ Oct 9, 212-24-0470 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No MD Allegany Cumberland Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number USA 21502 229 Baltimore Avenue Apt. 404 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a any nijury or other traumatic event, the Medical Examinat masts once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie (Fier) Mullan Reeves Vista L. Mullan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 11707 Crocus Avenue Cumberland Charles Morgan Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cemetery 5/19/2008 MD Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease r condition resulting in death) Cerebro Voisenlas Enysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus 3. E. as Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the s 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 2 No 1 🗌 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4☐Rursing Home 5☐ Residence ٩ 1 Yes 2 No 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 29d. Date signed (Month, Day, Year) 29b. Signature and pile of 00033250 17,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENTAVE. COMBERLAND, MD 21502 , M.D. 625 GUPTA DUNIL . Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

2 3 2008

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 46PM 2008 Elizabeth S. Martin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Doctors Community Hospital Lanham If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 M 2 X F 82 Director 371-22**-**8793 March 9, 1926 Detroit, MI Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or items 23a or 28a-f show aminer must be notified at 1XYes 2 No Director College Park MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number with U.S. 6100 Westchester Park Drive #1713 20740 Item 27 is marked other than "natural", or items 23s other traumatic event, the Medical Examiner must Funeral Department of Health and Mental Hygens.

In possible the street of Health and Mental Hygens.

Important: If Item 27 is marked other than "nature" any injury or other traumatic contents. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African 1 ☐ Yes 2 No Specify: 2 3 ₩ Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Sarah Merrit မ William Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Renaurd W. Harris / Son 12209 Westview Dr., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National Mem. 5/13/08 4 □ Donation 5 □ Other (Specify) Laurel, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. Funeral Service Licenses 21. Signature 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseguence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. aftending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a o 9 Unknown signed by t ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manger of Death 28c. Injury at Work? Certification: Division 1 Matural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ise of death (Item 23a) (Type, Print) 30. Name and address State 9 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Moffat, Sr. MA McKay Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HICOMICO SALISBUR ennsula Regional If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 X M 2 □ F 4-4-1933 Scotland Director 150-28-9877 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f showevent, the Modical Examiner must be notified at 1X Yes 2 □ No Director Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 24 White Crane Drive 21811 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify White à 3 Widowed 4 Divorced Completed Maryland 21215-0 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If Item 27 Is marked other the any injury or other traumatic event, I'm I once. Mason 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Moffat Catherine Johnston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebecca F. Moffat - wife 24 White Crane Drive, Berlin, MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 5-8-2008 Ewing, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) Ewing Crematory 22. Name and Address of Facility 21. Fignature Funeral Service Licenses Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebella hematera . Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Brainstum Sequentially list conditions, if any, leading to infrinciple cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a co Box 68760, Physician/Medical attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardionyopath 24a. Was an nas page 2 autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Division To the Hospital or within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Natural 5 ☐ Pending investigation Fall 5/6/08 1 ☐ Yes 2 No 0100 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Howe

24 white Care to let line wo

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal Medic and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie DME D55658 516108 me and address person who completed cause of death (min 23a) (Type, Print) Chris Smyder D.O. DME 100E Carroll St. 100E.

Registrar

State

State of Maryland / Department of Health and Mental Hygiene.  $\cup$ 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** May 05, 2008 8:20 P. Mary Eugene Monaldo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Emmitsburg, Frederick St. Vincent Care Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 9, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 ☐ M 2 ☑ F 1929 Washington, Director 579-34-7720 78 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County al Hygiene. I other then "natural", or items 23e or 28e-f show event, tre Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Directo MD Frederick Emmitsburg the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 335 South Seton Avenue 21727 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
snt: if item 27 is marked other than "natural", or items 23 ury or other treumatic event, the Maulcal Examinat must Completed by Funeral II.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 23 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Religious Community Elementary/Secondary (0-12) College (1-4or 5+) Daughters of Charity Teacher College 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Biagio Monaldo Caterina Ulise P 19a. Informant's Name/Relationship (Type, Print)
Sister Camilla Harant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 South Seton Avenue, Emmitsburg, MD 20b. Place of Disposition (Name of Streemen place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 5/9/2008 Emmitsburg, MD Provincial House 4 Donation 5 Other (Specify) 21. Silmature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727 بلتد morona 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Veuma **Physician** /Medical Due to (pr as a consequence of): Examiner umo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicisn: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Completed by Physician/Medical for use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. his certificate has been significated has been significated by a should be 2 NNo 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has 210 No 1 🗌 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 1 ☐ Yes 2 No Medical Certification; To 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending To the Hospitei or Attendir within 24 hours efter death.
To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exar iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 6 MIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. SETON AVE., EMMITSBURL, MD. 310 CARROLL 31. Date filed (Month, Day, Year) 32. Registar's Signature

Registrar DHMH 17 Rev 1/2001

State

08

2008

Box 68760. P.O.

		1	For State Registrar	State of	Maryland / Dep <i>Ce</i>	ertificate of			jiene leg. No. 00	8 16923
	<b>₩</b>		Decedent's Name (First, Middle	e, Last)	· -			2. Date of Dea Month		3. Time of Death
8	Physici /Medic	edical Patricia Nyce Milier						May	6, 20	08 12:45 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution	-	oer)		r Location of Death		4c. County of	
Y V		變	Genesis Eldero		Age (In yrs. last birthda		rna Park	8. Date of Birtl		Arundel  Birthplace (State or Foreign
П	Funeral Director		5. Social Security Number 220–14–4600	1 M 2 X F	82 Yrs.	Months Days	Hours Min.	Dec. 11	1925	Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent		UZ.			Dec. 11	1725	rialytana
	nylan how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	Ba-fs	cto		Arundel	Severn					
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	s 23e	erai	607 Cape McKi	Insey Drive			1146 Hispanic Origin? (Sr	pecify Yes or No-		SA American Indian,
	ther de	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar	Armed Ford		Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black,	White, etc.
ဗ္ဗ	urs al	<u>م</u>	3 Widowed 4 Divorced	If Yes Give	77-	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland Instural, or Hems 23e or 28e-f show disel Exac learmout be notified at	Completed		it's Education est grade completed)	(Gir	edent's Usual Occup	during most of world	king	16b. Kind of Busin	
7	ithin of	nple	Elementary/Secondary (0-12)	College (1-4	lite	DO NOT use retired	d)			e County School
72	iled w tygier thar ti	S	12 17. Father's Name (First, Middle,	l act)		Secreta			System -! Maiden Surname)	<u> </u>
anc	to pe di ed ot	Be	John Nyce	Casi				Turnbau		
Maryland	should be find Mental Is marked of	၉	19a. Informant's Name/Relations	ship (Type, Print)	19b. Ma	iling Address (Street				ate, Zip Code)
Š	nd 2 alth ar 27 ls r trau		Glenn F. Mille	er/Son	607	Cape McKi	insey Dri	ve Sev	erna Parl	c, MD 21146
re,	is 1 and 2 of Health a ltem 27 is othar trai		20a. Method of Disposition		cemetery c	position (Name of ematory or other plac	се) Мэ	Date v 12	20c. Location - Ci	ty or Town, State
Ĕ	Page nent c int: If		1 XBurial 2 Cremation 4 Donation 5 Other (S		MD Vete	rans Cemet	ery 2	y 12, 008	Crownsv	ille, MD
Baltimore,	permii. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28a-f show emprorant: if Item 27 is marked other then "natural", or Items 23e or 28a-f show emy injury or other traumatic event, Ite Medical Exa. It at mast the notified at ODGs.		21. Signature of Fungraf Service	Licensee		22. Name and Addre Barranco & 495 Gov. F	ess of Facility & Sons, P Ritchie H	.A. Sew wy. Sew	erna Parl erna Parl	k Funeral Home
	- 4		23a. Partl. Enter the disease, o shock, or heart failure. List	r complications that can t only one cause on ea	used the death. Do not e					Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	mul	tiple.	sclero	2545			Onset and Death URCUS
88	/Medical Examiner		resulting in death)	Due to (o	r as a consequence of):					0
	LXamiliei	_	Sequentially list conditions.	b	r as a consequence of):					
	pet nsit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>3</b> 200 10 (0	r as a consequence or.					
	axecu al-trai	xar	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of):					=
8760,	certificate be executed uding physician and use as the burial-transit	cail		d						
9	tificat ng phy as th	Medi	IS ESTATE							
Вох	eath certifi attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Detail death	B Ectopic pregnanc	y		23d. Date of	
	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	4□Pregna 9□Unknov		Other (specify)			Wilding	bay roat
P.0	that the de ted by the a detached		Part II. Other significant conditi	ions contributing to dea	ath but not resulting in the	underlying cause on	ven in Part I	23e. Did to	obacco use contrib	ute to the cause of death?
ds,	bed bed	d by	Turin out or digital and a second	on the soliting to do		underlying oddoo gr		10	/es 2 🗋 No 3	Probably 4 Denknown
Records,	v requir been s should	ompleted						24a. Was	an 24h. We	re autopsy findings available
Re	0 5 0	шc				<del></del>		autop perfo	osy pric rm∉d? dea	or to completion of cause of ath?
Vital	ician: Th certificate ector, pag	C	25. Was case referred to medica	al			26. Place dea	1 ☐ Yes		]Yes 2□No
$\geq$	S S	To B	examiner? 1 ☐ Yes 2 ₽ No	Hospital: 1 🗀 In	patient 2 ER/Outpat	ient 3 DOA Ott	nor A		dence 6 🗀 Other	(Specify)
n of			27. Manner   Death 1	28a. Date of (Month	Injury 28b. Time , Day Year) Injur		ry at rk?	28d. Describe I	now injury occurred	
sio	Attending r death. ector: After by the fune	cati		igation not be			Yes 2 No			
Division	or Ati	Certification:		nined 286. Place	of Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory, office		City or Tov	Street and Number vn, State)	or Rural Route Number,
	e Hospital or Attendate of hours after deatle Funeral Director: etely filled in by the	S	29a. Certifier 1 Certifyi	no Physician: To the I	pest of my knowledge, de	ath occurred at the fi	me date and place	and due to the	cause(s) and mann	er as stated
	24 hc	edicai			sis of examination and/or					
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of Sertific	er / 1		29c. Licens			29d. Date signed (	
	1-	1		1	N	10 E	10010	x2	5-6-	2008
•	300W		30. Name and address of person	who completed cause	of death (Item 23a) (Typ	e, Print)	11 .	1111	;/	2008 MD 21108
	Mrs.		Jenniterk	redinge	8601	Veterar	is thuy	Mille	rsville	MI) ×1108
	Sta Regist		31. Date filed (Month, Day, Year  M \( \D \)		gistrar's Signature	boots				
2	negist	Tell.	MAIO	7						

State of Maryland / Department of Health and Mental Hygiene ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Dorothy Gray Morzilla 2008 3:00 p <sup>M</sup> May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, You July 23, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours Min New York 1 □ M 2 🛛 F 89 072-03-6636 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examination to confined at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 41 W. McKinsey Road Apt. # 204 21146 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Gray Helen Blanchard ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kennedy/Son 1115 Spy Glass Drive Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 10, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funeral Service Lic 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hard to Limmond cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted 1 ∏ Yes 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Living 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the ft. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 028686 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) And no 1509 Riphie

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAY 0 8 2008

**ORIGINAL** 

pgistrar's Signature

MABLE RUTH NAUNDORF   More   Intermediate   Market   Ma		State Registrar		Ce	artment of F	Death		Reg. No. 2	08 1692	
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Social Section () Number   6.5 sec.   21.8 - 1.6 - 80.7 8   1.1	iner							4c. County o	f Death	
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Sale   100. Centry   100. City rore of Location   100. Centry   100. C	r	218-16-8078	]M 2 <b>X</b> ∫F	Vre			(Month, Day	r, Year)	Country)	
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1   1   1   1   1   1   1   1   1   1	ral									
Signification of Liberton of Disposition   Signification   S	ij.		Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)			
EDWARD L. FETTEROLF   18. Mailing Address (Steet and Number or Rusil Rode Number, City or Town, State, Zip Code)	2		If Yes, Give		1 ☐ Yes 2 【XNo	Specify:		Specify:	WHITE	
EDWARD L. FETTEROLF   Tight Mailing Address (Street and Number or Rural Roles Number, City or Town, State, Zip Code)	eted			) (Give	kind of work done	during most of work	rina I	16b. Kind of Bus	iness/Industry	
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EDWARD L. FETTEROLF   MABLE ALICE TAYLOR	္တို			<u> BAF</u>	RTENDER	18. Mother's Name	e (First, Middle,			
19s. Maling Address (Street and Number or Rusal Route Number, City or Town, State. Zip Code)	Ŏ	EDWARD L. FETTERO	LF						,	
20h. Method of Disposition   1 Misural 2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   1 Chemistry   2   2   1 Chemistry   2   2   1 Chemistry   2   2   1 Chemistry   2   2   1 Chemistry   2   2   2   2   2   2   2   2   2									State, Zip Code)	
ABurtial 2   Coremation 3   Removal from State   CHESTER CEMETERY   4/27/2008   CHESTERTOWN, MD		·								
22. Name and Address of Facility  22. Name and Address of Facility  23. Septim RD. CHESTERTOWN, MD 71620  23. Septim RD. CHESTERTOWN, MD 71620  23. Septim RD. CHESTERTOWN, MD 71620  24. Septim RD. CHESTERTOWN, MD 71620  25. Septim RD. CHESTERTOWN, MD 71620  26. Septim RD. CHESTERTOWN, MD 71620  27. Marrier death oceans that case of the death. Do not enter the mode of dying, such as cardiac or respiratory arreal, interval Between Shock, or heart failure. List only one cause on the death of the model of the death of the cause of the death of the d				20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac		Date	20c. Location - C	City or Town, State	
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28. Part I. Enfort the disease, of compfications that clause is the death. Do not enfer the mode of dying, such as cardiac or respiratory arrest.  Approximately list conditions, cause. Enfort of the death of the cause of the death of the cause of the death of the cause of the death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of		Huh of Je	Sobin	F	ELLOWS, H 30 SPEER	ELFENBEIN RD. CHEST	N & NEWN	AM FUNER	RAL HOME	
Due to (or as a consequence of):    Sequentially list conditions if any leading to immediate cause (Final disease or condition resulting in death) Last   Due to (or as a consequence of):		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ile cause on each ve.	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate	
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Due to (or as a consequence of):    If FEMALE:	<u>.</u>	Sequentially list conditions,		onsequence of):						
Due to (or as a consequence of):  d.  IF FEMALE: 23c. If yes, outcome pf pregnancy in the past 12 months? 1   Live pirth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)   Month Day Year 1   Live pirth 2   Fetal death 5   Other (specify)   Month Day Year 1   Live pirth 2   Fetal death 5   Other (specify)   Month Day Year 1   Live pirth 2   Fetal death 5   Other (specify)   Month Day Year 1   Live pirth 2   Fetal death 5   Other (specify)   Month Day Year 1   Live pirth Day 1   Other significant conditions		cause. Enter Underlying		311334251133 3171					Į.	
FFEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1	Ĭ,	resulting in death) Last	Due to (or as a c	onsequence of):						
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)	lca lca		d							
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   1   Yes   2   No	/Me		3c. If ves. outcome of	pregnancy				and Date	.15	
25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death Natural Solucide Homicide Injury (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Place of Injury At home, farm, street, factory, office  28c. Injury at Work?  1	ciar	in the past 12 months?	1 ☐ Live birth 2 [	☐ Fetal death 3 ☐						
25. Was case referred to medical examiner?    1	2		9□Unknown							
24a. Was an autopsy findings avail prior to completion of cause death; and prior to cause death; and prior to caus		Part II. Other significant conditions co	libuting to death but	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?	
25. Was case referred to medical examiner?    Yes   2   No		Julie 1	7-010-10	co			1 🗆 Y	es 2 No	B ☐ Probably 4 ☐ Unknow	
25. Was case referred to medical examiner?	nple						autop	sy pr	ior to completion of cause of	
Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other:   Nursing Home   5   Residence   6   Other (Specify)										
27. Manner of Death   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28a. Date of injury - At home, farm, street, factory, office   28c. Injury at Work?   1   Yes   2   No   28c. Location (Street and Number or Rural Route Number, building, etc. (Specify)   28a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29c. License number   29c. License number   29c. License number   29d. Date-signed (Month, Day, Year)   29c. License numbe	n	examiner?	fospital:	2 □ EP/Outpation	othe Othe					
29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		27. Manner of Death	28a. Date of Injury	28b. Time o	" JUDON	WEJ Nursing Ho				
29a. Certifier (Check only one)  1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  39. Name and address of person (Wo completed cause of death (Item 23a) (Type, Print)  39c. Name and address of person (Wo completed cause of death (Item 23a) (Type, Print)  39c. Name and address of person (Wo completed cause of death (Item 23a) (Type, Print)  39c. Name and address of person (Wo completed cause of death (Item 23a) (Type, Print)  39c. Name and address of person (Wo completed cause of death (Item 23a) (Type, Print)	2	2 ☐ Accident investigation	(Month, Day Y	ear) injury						
29a. Certifier (Check only one)  1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person (N) completed cause of death (Item 23a) (Type, Print)  30. Name and address of person (N) completed cause of death (Item 23a) (Type, Print)  31. Name and address of person (N) completed cause of death (Item 23a) (Type, Print)  32. Name and address of person (N) completed cause of death (Item 23a) (Type, Print)  33. Name and address of person (N) completed cause of death (Item 23a) (Type, Print)			28e. Place of injury building, etc. (	- At home, farm, str Specify)	eet, factory, office				r or Rural Route Number,	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person (No completed cause of death (Item 23a) (Type, Print)  30. Name and address of person (No completed cause of death (Item 23a) (Type, Print)  30. Name and address of person (No completed cause of death (Item 23a) (Type, Print)  31. Name and address of person (No completed cause of death (Item 23a) (Type, Print)		200 Codifice 1 Devicting Plans	inian: To the heat of r	ny knowloden, doet	h oppured at the ti-					
30. Name and address of person (who completed cause of death (Item 23a) (Type, Print) Rown PD STES CAPSTRANOW.	dica	(Check only 2 Medical Exami	<b>ner:</b> On the basis of ex	ramination and/or in	vestigation, in my o	pinion, death occur	red at the time,	date and place, ar	ner as stated. nd due to the cause(s)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print). ROWN PD STES CAPSTEMOWN.	Me	29b. Signature and title of certifier	050		<b>N</b>			29d. Date signed	(Month, Day, Year)	
		/ Vacata	impleted cause of deat	h (Item 23a) (Type,					01	
		3D. Name and address of person who do			A 1 1 -	1311				

DHMH 17 Rev 1/2001

08-03747 Shannon Amy Newton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	011 7 thing 1.		- For State Cert	ificate of Death	Reg. N	
	Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da	3. Time of Death  Year 1526 hrs
/ledic	al Exami	ner	Shannon Amy Newton		May 16, 2008	4c. County of Death
•			4a. Facility Name (if not institution, give street and number) 2311 Salt Lake Road	4b. City, Town, or Location of White Hall		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Ia:	st birthday) If Under 1 Year If Under Months Days Hours	Min.	MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
	Director	1	213-13-0058 1 M 2XXF 25	Yrs.	10/28/1	982 Maryland
	y	F	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Fown or Location		10d. Inside City Limits
	d 10w any		Tod. State	hite Hall		1 X Yes 2 No
	rryland Sa-f sh at onc	횽	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
9	th the Maryland 23a or 28a-f sho notified at once.	Director	2311 Saltlake Road	21161	τ	J.S.A.
216	Pages 1 and 2 store of the Maryland Pages 1 and 2 should be filled within 72 hours after death with the Maryland tent of Healigh and Mental Hygiene. Intent of Healigh and Mental Hygiene "natural", or items 23a or 28a-f she intent if item 27 is marked other than "natural", or items 23a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S	<ol> <li>13. Was Decedent of Hispanic Original Street</li> <li>If Yes, specify Cuban, Mexican</li> </ol>	gin? ( Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
_	r death or ite must	E.	1 Yes 2 X No	1 Yes 2X No specify:		Specify: White
	rs afte oral",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give	kind of work done	6b. Kind of Business/Industry
	2 hour "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)	
350	thin 7	mple	12	Driver		School bus
24E 003E	Hygie I othe		17. Father's Name (First, Middle, Last)		's Name (First, Middle, Mai	den Surname)
121	uld be fill Mental F marked c event, 1	Be	Charles Mullins  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Nur	rol Jernigan mber or Rural Route Numbe	er, City or Town, State, Zip Code)
MD 24	7, IND 21210000000000000000000000000000000000	2	Jaysen Newton (Spouse)	2311 Saltlake Ro		
2	s 1 and 2 sl of Health as If item 27		20a, Method of Disposition 20b. F	Place of Disposition (Name of cemetery, rematory or other place)	Date 2	20c. Location - City or Town, State
ì	ages 1 nt of 1 other		1 Buria 2 Cremation 3 Removal from State	A. Ferris & Co.	5/24/08 V	Vest Chester, PA
- 1	permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	H	21. Signature of Fu	22 Name and Address of Facilit	V	
à	E P E		My benie	Tarring-Cargo Aberdeen, Mary	yland 21001-	1. shock, or heart Approximate Interval
F	Physician /Medical		23a. Part I. Enter the dilease, complications that caused the death failure. List only one cause on each line.		cardiac or respiratory arrest	Between Onset and Death
	taminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence o	oin ] Intoxication		
			h			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	f):		
		Examine	C)  (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the co	f):		
	rou, icate be executed physician and the burial - transit	Ě	d			
	e exection a cian a cial a	Medical	X UNPENDED AMENDED #. 23a,27	7,28a-f per MEO G-880 6/	16/08 reb	
	reate be physic the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of preg	Fotor	oic pregnancy	23d. Date of delivery  Month Day Year
Ć	SOX 501  leath certific e attending p	Physician	past 12 months?  4 Pregnant at time of de			
C	be death the att	hysi	1 Yes 2 No 9 V Unknown g Unknown		220 Did toh	acco use contribute to the cause of death?
9	DIVISION Of VITAI RECORDS, P.O. BOX 80/00,  To the Itospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transi	by Pl	Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause given in F		2 No 3 Probably 4 ✓ Unknown
	uires I an sign lid be	per			24a. Was ar	24b. Were autopsy findings available
7	aw rec aw rec nas bec 2 shou	Completed			autops:	ned? death?
	The 1	l o		26 Place of Deat	1 Yes 2 h (Check only one)	No 1 ✓ Yes 2 No
•	tal ician: certif rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other:		Residence 6 Other: Scene
	Phys Phys er this	P	1 V Yes 2 No 28a. Date of Injury	28b. Time of Injury 28c. Injury at Wo	rk? 28d. Describe ho	ow injury occurred
	on Control of the Con	tion	1 Natural 5 Pending Fnd 5/16/08	Fnd. 3:20pm 1 Yes 25	I OUR DAM	
:	IVISIOF  Or Attend after death. Director: d in by the	fica	2 Accident Investigation 3 Suicide 6 Could not be	nome, farm, street, factory, office building,	etc. 28f. Location (Sf or Town, St	treet and Number or Rural Route Number, City ate) 2311 Salt Lake Rd.
i	pital o	erti	4 Homicide determined (Specify) Found:	residence	White F	all, Md
	DIVISION OF VITAL RECORDS, P.O. To the Itespital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be deach completely filled in by the funeral director, page 2 should be deach	E	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination	dge, death occurred at the time, date and pand/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	e(s) and manner as stated.  and place, and due to the cause(s)
	To the within To the comp	Medical Certification:	one) 2 Medical Examiner: On the basis of examination and manner stated.  29b. Signature and title of certifier	29c. License numbe		29d. Date signed (Month, Day, Year)
		2	12/12/1	O.C.M.E.		May 17, 2008
			30. Name and address of person who completed cause of death (Iter	n 23a)		
			Zabiullah Ali, M.D. Assistant Medical Examine		, MD 21201	
			31. Date filed (Month, Day, Year) 32 Registrar's Signa	N ETABLES ETA		OCME
	Regi					

			1 - For State Registrar	State of M	Maryland /		artmen tificate				_	giene Reg. No.	008	169	27
ı	Physic	ian	1. Decedent's Name (First, Middle, Li	ist)							2. Date of De Month	Day	Year	3. Time of 4:10	_
	/Medi	cal	Annie L. Oliver  4a. Facility Name (If not institution, gi				4 0			10 10	May	02	2008	23:10	Ам
	Exami	ner	3517 Payne Road	e street and numbe	9F)		, .		Location				ounty of Death		
	Funeral	_	-	Sex 7.7	Age (In yrs. last b	oirthday)	If Under	1 Year	∢e Ci ∥fUnder	24 Hrs.	8. Date of Bir	th	Orcesto	er place (State ontry)	r Foreian
	Director		214-28-8442	1 □ M 2 □XF	74	Yrs.	Months	Days	Hours	Min.	NOV 21	. 19 <b>3</b> 3	Cou	ntry) MD	
	pug 🔏		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox										
	Aarylan I show	5	MD Worces	ter			cation City	7						10d. Inside Ci 1√∑ Yes	•
	the M 28a-f	rect	10e. Street and Number			TROIS C	10f. Zip			-		10a Citiza	en of What Cou	3.	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	3517 Payne Road				218					-	USA	uy:	
		nera	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. V			spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		. Race - Ameri		
9	after or ite		1 Never Married 2 Married	Armed Forces	X No	1					Rican, etc.)		Black, White,		
8	72 hours after "natural", or ite	d by	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates			☐ Yes 2		Specify:			S	pecify: Bla	ick	
갻	naf	Completed	15. Decedent's E (Specify only highest gr	ducation ade <i>completed)</i>	168	a. Deced (Give i	ent's Usua kind of wor OO NOT us	l Occupa k done d	ition <i>uring mos</i>	t of work	ing	16b. Kind	of Business/In	dustry	
212	s within piene. r than "	Eo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		Bus M					Poa	rd of E	ducat i	on
פ	be filed within 72 h Ital Hygiene. Id other than "natu evant, the Medical	BeC	17. Father's Name (First, Middle, Last	)						or's Name	(First, Middle,			aucat 1	OII
<u>Va</u>	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Me	To	John Teagle						Edit	h Wa:	rd				
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship										οwπ, State, Zip	Code)	
	1 and fealth sm 27 ther t		Sandra K. Branch, 20a. Method of Disposition	daughter	20b. Place 0				d, Po		oke Cit				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marka any injury or other traumatic. <u>once.</u>		1 Burial 2 ☐ Cremation 3		e ME	ery, crem Si na	atory or off	ner place	)		ate		tion - City or To		
ij	artme artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Special Service Lice		Chi	urca	Ceme Name and	tery			/2008	Poco	moke Ci	ty, M	)
Ba	permit. Departr Importa any inji		Talana	Waters		Le	wis N	• Wa	tson	Funa	eral Ho Sbury,	me MD 21	801		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceuse one cause on each	ed the death. Do line.	not ente	r the mode	of dying	such as	cardiac c	r respiratory a	rrest,		Approximate Interval Bets	e een
	Physician		Immediate Cause (Final disease or condition	a Cere+	mal VI	2)4	wa.	R.	PISE	as	0			Onset and [	Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence	of):	11 1.								
ı		ja	Sequentially list conditions,	b. Due to (or a	s a consequence	Yell I	HIM	$\bigcap$							
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(3. 4		3.7.									
o,	sician and burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or a	s a consequence	of):									
8760,	at A	dical		. d											
9	death certifics attending pl	Med	IF FEMALE:								100	- 1	- 3		
Вох	ath cattend	ian/	23b. Was decedent pregnant in the past 12 months?		2 - Fetal death		Ectopic pre					230	d. Date of delive Month	•	'ear
o.	that the de led by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 🗌	Other (spe	cify)					17101101		oui
Δ.	res that I		Part II. Other significant conditions of	ontributing to death	but not resulting i	in the und	derlying car	use giver	n in Part I.		23e. Did to	obacco use	contribute to th	e cause of d	eath?
Division of Vital Records,	quires n sigr ald be	Completed by									101	es 2	Vo 3⊡Prob	ably 4 ∐U	nknown
000	faw require as been si 2 should b	olete	Chennic &	ania0 1	Facture	10					24a. Was	an 2	24b. Were auto	psy findings a	vailable
R	The tate ha	E O				<u> </u>				_	autop perfo	rmed? 2 2 No	death?	npletion of ca 2□ No	use of
'ita	ician: Th certiticate ector, pag	Bec	25. Was case referred to medical examiner?		-				26. Place	of Death	(Check only o			2010	
<u>5</u>	Physician: this certitic ral director,	2	1 Tyes 2 No	Hospital: 1   Inpat		utpatient	3□ DOA	Other	4 □ Nui	rsing Hor	ne 5 Mesic	dence 6	Other (Specify	)	
n C	ding P th. : After i	ion:	27. Manner of Death 1 Statural 5 □ Pending	28a. Date of Inj (Month, D		Time of Injury		c. Injury a			8d. Describe h	ow injury o	ccurred		
isi	Pe sa	icat	2 Accident investigation 3 □ Suicide 6 □ Could not be		iun. At hama fe		М		es 2⊡N	-	104 11' (6				
Θ	atter atter Direct	Certification:	4 Homicide determined	building, e	njury - At home, fa etc. <i>(Specify)</i>	arm, stree	et, factory,	office		2	City or Tow		lumber or Rura	l Route Numi	oer,
	To the Hospital or Att.  -within 24 hours atter de To the Funaral Directe completely tilled in by t	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis of and manners	ot examination an	e, death nd/or inve	occurred at estigation, i	t the time	, date and nion, deat	d place, a	and due to the o	cause(s) an date and pla	d manner as st ace, and due to	ated. the cause(s)	
	To the To the comp	Σ	29b. Signature and title of certifier	10			29c.	License	number			29d. Date s	igned (Month,	Day, Year)	
	4501		Muyal	lela			I	24	871			5/1	2/00		
	. 00		30. Name and address of person who	completed cause of	death (Item 23a)	(Туре, Р	rint)	000	201	) (a	mo	218	51		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 0 8 20	32. Pegist	rar's Signature	1	2000		21.00	,	4 1				
	riegisti	-11	WIATUOZU	OU JULIE	A. A. A.	A STATE OF	-								

	328 ann Cordel				ible. 200	18 1692
			For State Certificate of Death		, No.	
, .	Physici cal Exami		1. Decedent's Name (First, Middle, Last)  DeShann Cordell Prophet	2. Date of Death Month May 1, 200	Day Year	3. Time of Death 1100 hrs
	AI EXAM		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of Deatl	1
			Bunker Hill Road Waldorf		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24H   Months   Days   Hours   Mi	in	Co	thplace (State or Foreign ountry)
	Director		567-93-1319   1X M 2 F   21 Yrs.   Months Days Hours M	09/20/	/1986	IL
	uà	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	d Fe ma Ge ma		MD Charles Indian Head			1 X Yes 2 No
	arylan 8a-f sl at one	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Dire	51 Mattingly Ave. 20640		USA	
	n with ms 23 be no	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( 14. Was Decedent of Hispanic Origin? ( 15. Was Decedent of Hispanic Origin? ( 16. Was Decedent of Hispanic Origin? ( 17. Named Forces? If Yes, specify Cuban, Mexican, Puer		14. Race - Amer White, etc.	ican Indian, Black,
	r deatl or ite must	Funeral	1 Yes 2 X No	10 / 1001 / 1001 /	В1	ack
	rs afte ural", miner	à	3 Widowed 4 Divorced If Yes, Give Yeer 1 Divorced If Yes, Give Yeer 1 Divorced If Yes 2 No specify: or Dates  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind o	f work done	Specify: 16b. Kind of Business.	Industry
	2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			
	U36 ithin 7 ne.	ם	12th 1 Security Guard		Governme	nt Buildin
1	5-0 iled w Hygie I othe			me (First, Middle, M	•	
	121 Id be f Aental narke event,	o Be	Derek Troupe Jannie  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of Street and Number of	e Prophe		e Zin Code)
į	Baltimore, MID 21215-U036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fsh injury or other traumatic event, the Medical Examiner must be notified at once	Ĕ	Jannie Prophet/Mother 51 Mattingly Ave,			
	e, N I and Health item	ł	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City o	
	nor		1 X Burial 2 Cremation 3 Removal from State Resurrection Cemet 05	5/08/08	Clinton,	MD
	Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21. Signature of Fune and Address of Facility 0			
			Strickland Fune			
	Physician 'Medical		23d Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	≟xaminer	ı	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):			Death
			Sequentially list conditions,  b.			
		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			E.
	.=	xam	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	<del></del>	<del></del>	1
	f 60, ficate be executed g physician and the burial - transit	- 1	d			
	D, be existian sician	ğ	UNPENDED			
	BOX 68 / 60, death certificate by he attending physic for use as the but		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nancy	23d. Date of delive Month	ry Day Year
(	Box 68 e death certiff the attending ed for use as it	icia	past 12 months?  Pregnant at time of death 5 Other (Specify)			
	he dea	ξ.	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute t	the cause of death?
	Cords, P.O. B law requires that the d has been signed by the 2 should be detached		Part is. Other significant conditions continuing to death but not resulting in the underlying cause given in rait is		2 <b>✓</b> No 3 Pro	
	ords, w require is been sig should be	Completed by		24a. Was a		utopsy findings available
	COL lawr has b e 2 sho	힅		autops perfor	med? death?	completion of cause of
1	H Ke		25. Was case referred to medical 26.Place of Death (Cher	1 ✓ Yes	2 No 1 🗸	/es 2 No
	1 of Vital Records,  ling Physician: The law requir  After this certificate has been s  funeral director, page 2 should	o Be	evaminer?		Residence 6 🗸 Oth	er: Scene
	ing Phy After the		27. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury at Work?		now injury occurred	1 object
	ttendi teath.	aţ;	1 Natural 5 Pending May 1, 2008 1100 hrs 1 Yes 2 No	1317 PRO P. N.		
	DIVISION pital or Attendir ours after death. reral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway		Street and Number or F tate) oad / Rt. 228 , Wald	Rural Route Number, City
1	E 6 P		29a. Certifier A Cartifician Dhusialani. To the heat of multipopulation death occurred at the time date and place as			
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre	and due to the caus	and place, and due to	the cause(s)
	F Wit	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (M	
	(5)		OME.		May 2, 2008	
	000		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD Assistant Medical Examiner 111 Penn Street Baltimore MD 212	201	-	

DHMH 17 Rev 1/2001 OCME 2006

State 31 Date filed (Month, Day, Year)
Registrar MAY 1 2 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Henry 1:05 AM 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice House Las Talbot 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 262-72-4770 1**12**M 2□ F Days Months Hours Director Florida Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director albo Michaels 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21663 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or hany injury or other traumatic event, the Mariana once. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) acht Kitchen Helper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 41 berta ၉ Louis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Michaels Drucilla Dobson Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chos, thomas cometery 5/10/08 Sti Michaels. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HENRY FUNERAL HOME, P. 5 10 washington St. Cambr 23a. Pake. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC PROSTATE CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗌 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? 1 ☐ Yes 2□ No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) House Hospital: 1 ☐ Inpatient Certification: To 1 ☐ Yes 2 🔭 No 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

Vans

8005, TALANT

29c. License number

D0057908

ST. MICHTELS MD

29d. Date signed (Month, Day, Year) 518108

and manner stated.

Meter men my

sistrar's Signature

ATTENSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2008

		For State Registrar	State of Ma	ryland /		artment of F			ental Hy	/gien	0.13	0.8	15	930
ß =	194	1. Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of					Death
Physic		GEORGE WESLEY PENNELL, JR.							Month Day Year 5/2/2008					
/Medi		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							5/2/2008 9:57 P 4c. County of Death					
LXaiiii	101 54	10550 WORTON RD.	,			LIODTON				7.	ZENIE			
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last i	birthday)	WORTON If Under 1 Year		er 24 Hrs.	8. Date of Bi	rth	KENT	9. Birthpl	ace (State o	r Foreign
Director		222-20-6417	XM 2□ F 7	1	Yrs.	Months Days	Hour		(Month, D 8/7/19		)	Count	try)	DE
D		Usual Residence of Decedent							0/1/12	0.0				
rylan how		10a. State 10b. County		10c. City, To	own or Lo	cation						10	0d. Inside Cit	-
e Ma a-f s	cto	MD KENT		WORTO	N								1 ☐ Yes	2 <b>X</b> ) No
or 28	)ire	10e. Street and Number		-		10f. Zip Code				10g. Ci	itizen of Wh	at Count	try?	
th wi	a [	10550 WORTON RD.				21678				US	SA			
yial ILL Z IZ I 3-UU30  build be filed within 72 hours after death with the Maryland Mental Hygiene.  Merked other than "natural", or items 23a or 28a-f show arked other, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. \	Was Decedent of H	ispanic (	Origin? (Spe	city Yes or N	0-	14. Race -			
or it		1 ☐ Never Married 2 🕅 Married	1 XYes 2 No			1 □ Yes 2 Ū <b>X</b> No	Speci		mean, etc.)			White, e	eic.	
hours a cural", call Exar	d by	3 Widowed 4 Divorced	Year or Dates: 5	4-56		22110	Opeci	.,,.			Specify:	WHI	LTE	
72 h 72 h inatt	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16	Ba. Deced (Give	lent's Usual Occup kind of work done o DO NOT use retired	ation during m	ost of workir	na	16b. k	Kind of Busi	ness/Ind	ustry	
ithin ne. han '	ם	Elementary/Secondary (0-12)	College (1-4or 5+)				-		5					
IN CIC	S	12		C	OLLE	CTION OFF					BANKIN			
be fill dot	Be	17. Father's Name (First, Middle, Last)							(First, Middle	e, Maidei	n Surname)	,		
ite, INIAI VIAIIU Z IZ-UUJO 8 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Lygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	မ	GEORGE WESLEY PE						NA PET						
2 sho		19a. Informant's Name/Relationship (	Type. Print)	19	9b. Mailin	g Address (Street	and Nun	nber or Rura	l Route Numl	ber, City	or Town, St	tate, Zip	Code)	
1 and 1 health Health em 27 https://www.trans.com/		FRANCES C. PENNE	LL/WIFE			O WORTON	RD.							
Pages 1 nent of H		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	20b. Place ceme	of Dispo- tery, cren	sition (Name of natory or other plac	ce)	D	ate	20c. L	ocation - C	ity or Tov	wn, State	
		4 ☐ Donation 5 ☐ Other (Specifi		ST.	JAMES	S UMC		5/6/2	008	WOR	RTON,	MD		
permit. Departr Departr Importa any inju		21. Signature of Funeral Service Licer	isee		22 F I	. Name and Addres	ss of Fac	cility	c NEU				OME	
		Spen fellows				30 SPEER							OFIE	
		23 rt1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	ne death. D	o not ente	er the mode of dyin	ig, such	as cardiac o	r respiratory a	arrest,			Approximate Interval Bety	) ween
Physician		immediate Cause (Final disease or condition	-		un	ora A	700	+					Onset and E	eath
/Medical		resulting in death)	Due to (or as a	consequenc	e of):	ary Ax		7						
Examiner		Construction line time and distance	, GASTINT	- CA	ZUN	ona								
7 +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequenc	a ut).									
cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	C											
an ar		resulting in death) Last	Due to (or as a	consequenc	e of):									
icate be executed physician and the burial-transit	dical		d											
	led	15.551411.5												
The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2		uth 2	Ectopic pregnancy	,				23d. Date	of deliver	ry	
deat e attr	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at til			Other (specify)					Monti	n i	Day Y	'ear
by the grached tached	hys	9 ☐ Unknown	9□Unknown						_					
res tha igned be det	ру Р	Part II. Other significant conditions of	ontributing to death but	not resulting	in the un	nderlyin <b>g</b> cause give	en in Pai	t I.	23e. Did	tobacco	use contrib	ute to the	e cause of de	eath?
w require been sig		Hyperteusion							1 🗆	Yes 2	2 No 3	☐ Proba	ably 4 □U	nknown
aw re	Completed								24a. Was	an	24b. We	ere autor	sv findings a	vailable
The law cate has page 2 s	Ĕ								auto	psy ormed?	dea	ath?	sy findings a apletion of ca	use of
	ပိ	25. Was case referred to medical					OC DIA	as of Death	1□ Yes		0   1	Yes 2	2□No	
ysician: is certific director,	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 🗆 🗆 🗆	Jutnation	t 3 DOA Othe			Check onl					
Phy er this	$\vdash$	27. Manner of Death	28a. Date of Injury		. Time of				ne 5 Res 8d. Describe				)	
dlng I h. After funer	tior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	(ear)	Injury	28c. Injun Work	k? Yes 2				,			
Attener death rector: by the	fica	3 Suicide 6 Could not be	28e. Place of injury	- At home,	farm, stre				8f. Location	Street au	nd Number	or Bural	Route Numi	her
after Dire	Certification:	4 Homicide	building, etc.	(Specify)					City or To	wn, State	e)			,
spital or lours afte neral Dir		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowled	ge, death	occurred at the tin	ne, date	and place, a	and due to the	cause(s	and mann	ner as str	ated.	
in the Hospital or Attending Physician: within 24 hours after death of the Funeral Director: After this certification properties of the funeral director; and the funeral dire	edical	(Check only 2 ☐ Medical Examone)	niner: On the basis of e and manner state	xamination a	and/or inv	estigation, in my o	pinion, c	leath occurre	ed at the time	, date an	nd place, an	d due to	the cause(s)	)
To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	e numbe	r		29d. Da	ate signed (	Month, E	Day, Year)	
F 3 F 0		100 n.	110 200	Λ .		123	C.	G						
5	-	30. Name and address of person who d	year on M	th (item 225	) (Tupo I	Print)	209	/		J	13/0	8		
Tm		30. Name and address of person who of the R. ATZR A  31. Date filed (Month, Day, Year)	BAL-VW 1	(ILOIII 23a	223	1486 C	Lun	TIK	lest.	6 . A	711	001	633	
) m Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	رب	10.80 37	Re	10/1	-, ruse f	acol	1	7	400	
Registr		MAY - 7 2	32. Registrar's	K	de	ants.								
HMH 17 Rev 1/20	001		1		14									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Naomi Martin Reese May 2008 17:40p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly, MD Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 0 Month Day. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2√F 254-70-5085 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits at MD Prince George's Upper Marlboro r 28a-f sh Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be I 11022 Belton Street 20774 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: Black 3 Widowed 4 Divorced 'natural", Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Inspector Manufacturing Comp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessie R. Reese Amanda Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C Reese/Son 11022 Belton St., Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 3 ☐ Removal from State Lincoln Cemetery 05/09/08 | Atlanta, GA 5 Other (Specify) 21. Signature 22. Name and Address of Facility 6500 Allentown Rd, Camp Strickland Funeral Services, Spring, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC, ARRYTHMIA FATAL /Medical Due to (or as a consequence of): **Examiner** CANCER LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death ed by the a detached f 5 Other (specify) 9 Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2,2 No certificate 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No After this 1 Inpatient 2 X ER/Outpatient 3 □ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No the Funeral Director: npletely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in my opinion death account at the cause(s) and manner as stated

24

Registrar

Medical

29a. Certifier

30. Name and address of pe

32. Registrar's Signa 31. Date filed (Month, Day, Year) MAY 1 2 2008

and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

08-02704 Robert Marcus Reid	Please Type or Print in Black Indelible Ink. Ensu State of Maryland / Department of Health a	
	1- For State Certificate of Death	Reg. No. 2008 1693
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Robert Mark Reid ROBERT MARCUS REID	2. Date of Death Month Day Year April 6, 2008  3. Time of Death 0710 hrs
	4a. Facility Name (if not institution, give street and number)  Prince George's Hospital Center  4b. City, Town, Cheverly	or Location of Death  4c. County of Death  Prince Gebrge's
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 You Months Day 1	ear If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign American Sept. 30, 1976 Country) Jamaica
nd how sny ££.	Usual Residence of Decedent  10a. State	10d. Inside City Limits 1 Yes 2 XNo
tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 10f. Zip Code 13543 Georgia Avenue, #3 209	
r death with 1 or items 23: must be not	11. Marital Status  12. Was Decedent Ever in U.S.  1 Never Married  1 Yes 2 No  13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? ( Specify Yes or No- pan, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
nours after natural", caminer y	during most of working I	No specify: Specify: Black pation (Give kind of work done ife. DO NOT use retired)  Specify: Black 16b. Kind of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th Maintanenc	e Worker N.I.H.  I 18 Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Complé	17. Father's Name (First, Middle, Last) Donald Reid  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Str	Elaine Walker reet and Number or Rural Route Number, City or Town, State, Zip Code)
, MD 21 und 2 should salth and Me em 27 is ma raumatic ev	Patrick Walker (Uncle) 13543 Geor	gia Avenue #3, Silver Spring,MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 X Burial 2 Cremation 3 Removal from State (rematory or other place) 4 Ponation 5 Other Specify: 21. Signature of Funeral Service (1.5) fixed (2.5) Name and Address	en Cem 4/19/08 Silver Spring,MD ess of Facility SNOWDEN FUNERAL HOME,P.A.
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyir failure. List only one cause on each line.  Immediate Cause (Final disease a. gunshbt wound of chest	Washington St, Rockville, MD 20850  ng, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
kaminer	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
i xaminer	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
executed an and al - trans	d.   X 4MFNDED   X 4MFNDED   X 2879 5/23/08 TT	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans edical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
, P.O. Bc res that the des signed by the a be detached fo d by Phys	Part II. Dther significant conditions contributing to death but not resulting in the underlying caus	se given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, rat or Attending Physician: The law require is after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should bertification: To Be Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No
Vital F sysician: this certifit I director, I	examiner? 1 ✓ Yes 2 No  Hospital: I Inpatient 2 ✓ ER/Outpatient 3 DOA	oce of Death (Check only one)  Other 1 Nursing Home 5 Residence 6 Other:
ion of tending Pheath.  for: After the funeral	(Month, Day, Year)	njury at Work?  28d. Describe how injury occurred  Subject shot
Division o Hospital or Attending 24 hours after death. Flumeral Director: After filled in by the fune.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office (Specify) Basement of residence	or Town, State) 4704 66th Place, Hyattsville, Md
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time. one)  Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	, date and place, and due to the cause(s) and manner as stated. ion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed dauge of death(Itém 23a)
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year)

MAY 2 3 2008 2. Registrar's Signature

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

April 7, 2008

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Mary K. Reed 10:20 /Medical May 6, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6226 Basket Switch Road Worcester Newark 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months 1 □ M 2 🕅 F Director 202-20-6982 81 4/3/1927 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at Worcester 1 ☐ Yes 2 TNo Director Maryland Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6226 Basket Switch Road 21841 USA hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) seamstress manufacturing permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Robert Reath Mary Weast ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Lehr/daughter 6226 Basket Switch Rd., Newark, MD 21841 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify 5/7/08 21. Signature of Funeral Service Li 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kerll 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hedalic encent about **Physician** /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Justo (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): burial-1 physician a Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1∏ Yes 2 No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: this 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Certification: To 5 Residence 6 □Other (Specify) After thi 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day 5 Pending investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, MAY 0 8 2008

29b. Signature and title of certifier

ess of person who completed cause of death (Item 23a) (Type, Print) Maretrach

29c. License number

Berlin, NO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. n8-03716 State of Maryland / Department of Health and Mental Hygiene 2008 Margaret Richards Certificate of Death 1- For State 3. Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Month Day May 15, 2008 Physician/ Margaret Louise Richards L Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dorchester Cambridge 816 Locust Street 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) If Under 1 Year 7. Age (In yrs. last birthday) Foreign Washington Social Security Number April 10, 1956 **Funeral** Hours Months 52 Yrs Director 218-68-0014 M 2 X F Usual Residence of Decedent 10c, City, Town or Location 10a, State Cambridge Dorchester item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. MD 109. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10f. Zip Code 10e. Street and Number USA 21613 816 Locust Street 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 X Married white 2 X No Yes Specify: Yes 2X No specify: If Yes, Give Year Divorced 3 Widowed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed by 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) newspaper writer 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Dion Howard William Pyles Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cambridge. 816 Locust St. husband 20c. Location - City or Town, State Paul Richards 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Itimore, 1 X Burial 2 Cremation 3 Removal from State Marriottsville, MD Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr 5/21/08 rest Lawn Mem Gardens Donation 5 Other Specify: 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line Morphine intoxication 1edical Immediate Cause (Final disease ıminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical X UNPENDED 251,27,28a-f,perME,g881, 7/3/08 TI 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Be Completed by

Division of Vital Records, P.O. Box 68760,

d by Physiciar	Part II. Other significant conditions contri	Live birth 2 Fetal deatr Pregnant at time of death 5 Other (Sp Unknown ibuting to death but not resulting in the underlying	ng cause given in Part I. 2	1 Yes 2 🗸  24a. Was an autopsy performed?	se contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No
Be Complete	LOS Mas case referred to medical	al: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only of DOA Other, Nursing Hor		1 Yes 2 No
Certification: To E	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined	28a. Date of Injury (Month, Day, Year) Fnd 5/15/08 Fnd 4:00 28e. Place of Injury - At home, farm, street, faction (Specify) found at resid	28c. Injury at Work?  28d. u:  Yes 2 X No  u:  ory, office building, etc.  28f.  28f.	or Town, State) 6 Locust to the cause(s) an	nd Number or Rural Route Number, City St. CAmbridge, MD. d manner as stated.
Medical	1 298. Ceriller .   O. att.top Dhysician: T	the basis of examination and/or investigation, in	my opinion, death occurred at the 29c. License number	29d.	Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

1610 hrs

10d, Inside City Limits

1 X Yes 2 No

Approximate Interval Between Onset and

Death

Year

May 16, 2008

31. Date filed (Morth 124 Year) State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Tasha Greenberg MD.

Joine

Certification: To

OCME

lur

Assistant Medical Examiner

70

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

			partment of Health and M ertificate of Death		ene 008	16935
Discourse in the		Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
Physicia /Medica		APRIL LaSHAWN SHELL		MAY 15,	2008 Year	3:00P M
Examine	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
		HMS HEALTHCARE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	HAGERSTOWN  If Under 1 Year   If Under 24 Hrs.	R Date of Righ	WASHING	TON thplace (State or Foreign
Funeral Director		248-43-3487 1□M 2△F 31 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 4/3/197	Year) Co	H CAROLINA
g		Usuel Residence of Decedent		1707201		
arylar show	_	10a. State	Location CTINSBURG			10d. Inside City Limits 1XXYes 2 □ No
the M	Director	10e. Street and Number	10f. Zip Code	1/	og. Citizen of What Co	
with with		533 E. STEPHEN STREET	25401		USA	ountry r
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or tlems 23a or 28e-1 show ant, tra Madical Examiner must be notified at	Funeral		3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
after or the	邑	1XXever Married 2 ☐ Married 1 ☐ Yes 2 XXio	1 Yes 2 No Specify:	Hican, etc.)	Black, White	e, etc. BLACK
5-0036 72 hours at netural, or stead Example.	d by	3 Wildowed 4 Divorced Year or Dates:				
15-	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki o DO NOT use retired)	ing 1	6b. Kind of Business	Industry
212	mo	Elementary/Secondary (0-12)   College (1-4or 5+)	ASHIER		WAL MART	
e filed other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	laiden Sumame)	
	2	CURTIS SHELL	GLE	ENN K. N	ORRIS	
6 5 8 5 C			illing Address (Street and Number or Rura			
re, N s 1 and if Health item 27 other to			E. STEPHEN ST., MA		RG, WV 254	
0 0 = =		1 Burial 2 Cremation 3 Removal from State CMTT ICDI ID	rematory or other place)   MAY	19, 2	SMITHSBU	
		· Zoomanon · o Zomen (opeany)	22. Name and Address of Facility BR	OWN FLINERA		•
Balt permit. Depart Import any inj		Charles M. Bronen	327 W. KING ST., MAR			DOX 021,
		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	40, A1DS			Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):				7/200
		Sequentially list conditions, b. D	utertron			years
Je g is	ulue	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury)	uta -			Visson 12
at-train	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):			c	20001000
box 68/60, Codeath certificate be executed eatherding physician and dor use as the buriat-transit	dicail	d. 01/002/-	ums-6	nfee	40m	monles
	ded	IF FEMALE:				
BOX 6  eath certification attending processes as	an/	23h Was decedent pregnant 23c. If yes, outcome of pregnancy	∃ □Ectopic pregnancy		23d. Date of del	ivery Day Year
the deay the a suched for	Sic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Wildliff	Day
requires that the do	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
		(meinia)	/	1 ☐ Yes	3 2 12 No 3 □ Pr	obably 4 Unknown
Hecords, he law requires t e has been signe ige 2 should be	ompleted	- Sipplification & M	CO4 8	24a. Was an	24b. Were au	itopsy findings available
	E O	The state of the s		autopsy perform 1 Yes 2	ed? death?	itopsy findings available completion of cause of 2 No
VITAL Icien: T Certificat ector, pa	e Re	25. Was case referred to medical	26. Place of Death			2010
. S. S. S. S. S. S. S. S. S. S. S. S. S.	0	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat:		me 5 🗆 Resider	nce 6 Other (Spe	cify)
ding P	<u></u>	27. Manns Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how	v injury occurred	
ONISION  Tor Attending after death.  Director: After tin by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Ctr.	eet and Number or Ru	eral Pouto Number
lor A after Director		4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	State)	irai nodio Number,
ar sale of sal	ן כ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, a	and due to the car	use(s) and manner as	stated.
he Ho he Fu pletel	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
To t To t	Ξ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monte	h, Day, Year)
	1	MD)	2004508	01	may	200 8
\		30. Name and address of person who completed cause of death (Item 234) (Typ	a, Print) Ha	gen St	707.1	110 217
State	2	31. Date filed (Month, Day, Year) 22. Registrar's Signature	4	1 010		0-119
Registra		31. Date filed (Month, Day, Year)  MAY 2 3 2008	Vice I			

			State of Maryland / Dep	partment of Health and Mental Hygiene	6936
			Registrar  1. Decedent's Name (First, Middle, Last)	Heg. No.	0.200
P	Physic		Russell Frederick Schultz	Month	me of Death
	/Medi Examir			4b. City, Town, or Location of Death 4c. County of Death	2 07 1
	<u> </u>	44	1106 Holland Avenue	Cambridge Dorchester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min. (Month, Day, Year) Country)	State or Foreign
			Usual Residence of Decedent	Nov. 1, 1930   Illino:	LS
	arylan show d at	<u>_</u>	10a. State 10b. County 10c. City, Town or L	704.115	ide City Limits
	the M 28a-f notifie	ecto	Maryland Dorchester  10e. Street and Number	Cambridge	es 2□No
	3a or	Funeral Director	1106 Holland Avenue	10f. Zip Code 10g. Citizen of What Country? USA	
	ems 2	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American India	an,
36	s after , or it	by Fu		Black, White, etc.  □ Yes 2 □ No Specify: Specify: Specify:	
215-0036	2 hour atural cal Ex	ed b	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dece	White edent's Usual Occupation 16h Kind of Business/Industry	
215	thin 7% e. an "na Medi	Completed	(Specify only highest grade completed) (Giv life.  Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
2	filed within 72 hours after death with the Maryland Hyglene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ပ်	6 Nava	al Serviceman U.S. Military	7
Maryland	be pe pe pe pe pe pe pe pe pe pe pe pe pe	To Be	17. Father's Name (First, Middle, Last)  Georege Earl Schultz	18. Mother's Name (First, Middle, Maiden Surname)  Lucille Guy	
ary	2 should be and Mental is marked c aumatic eve	F		ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	ges 1 and 2 should nt of Health and Mer if item 27 is marke or other traumatic			06 Holland Avenue, Cambridge, MD 21613	
galtimore,	Pages 1 nent of H int; If ite iry or ot		TE Ballar 2 Colemation 3 Chemoval from State	osition (Name of Date 20c. Location - City or Town, Statematory or other place)	ite
	permit. Pag Department Important: I any injury o			ans Cemetery 5.23.2008   Hurlock, MD	
ď	Imp Der any		Molec torres Demweel 3	Name and Address of Facility Surran-Bromwell Funeral Home, P.A. St., Cambridge, MD 21613	
			26a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ater the mode of dying, such as cardiac or respiratory arrest,  Appropriately.	ximate al Between and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	t failure 34	thous
	Examiner		Due to (or as a consequence of):	totom.	4.5
1	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	110,1107	yews,
19.	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C		
/00/	e be e. sician e buria	calE	d d		
00	rtificat ng phy		IF FEMALE:		
O D	ath ce	lan/	23b. Was decedent pregnant   23c. if yes, outcome pf pregnancy   1 Live birth   2 Fetal death   3 line the past 12 months?	Ectopic pregnancy 23d. Date of delivery Month Day	Year
5	the de y the a	Physician/Med	1 □Yes 2 □No 4□Pregnant at time of death 5   9 □Unknown	Other (specify) Month Day	rear
Z,	s that gned b e deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause	e of death?
cords,	equire	ted t	Chronic obstructive pulmonary disease,	anemia of chroic 18 Yes 2 No 3 Probably	4 □Unknown
ָב ב	e law l has be	Completed	disease, Type II diabetes wellitus	24a. Was an autopsy find autopsy prior to completion	ings available of cause of
<u> </u>	n: Th ficate n, pag	-	25. Was case referred to medical	performed? death? 1	)
5	ysicia is certi directo	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only one)  11 3 □ DOA Other: 4 □ Nursing Home 5 🖾 Residence 6 □ Other (Specify)	
5	ng Ph After th	T:uc	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury	The state of the s	
2	ttendi death. :tor: A r the fu	cati	2 Accident investigation	M 1 □ Yes 2 □ No	
2	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route City or Town, State)	Number,
	Hospit 4 hours Tunera ely fille	edical (	29a. Certifier  (Check only  (Check only  2   Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and due to the cause(s) and manner as stated.  evestigation, in my opinion, death occurred at the time, date and place, and due to the ca	une(a)
	o the lithin 2	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Ye	
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1	off		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	OO
1	V		31. Date filed (Month, Day, Year)  32 Registrar's Signature	Byrn St. Cambridge, MD 31613	
	Sta Registra		MAY 2 3 2008	uli	
			7	The second secon	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Raymond Miles Smith 2, May 2008 4:21p./Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton, MD Prince George's 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/19/1942 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 161-32-2841 65 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits at MD Prince George's Clinton, MD notified Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be items 23a 20735 6111 Manor Road USA "natural", or items 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Systems Analysis Defense Industry 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Smith Sadie Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christyal Covington/Daughter 6111 Manor Rd, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/9/2008 Clinton, MD 4 Donation 5 Dother (Specity) Resurrection Cemet. 21. Signature of Funeral Se 22. Name and Address of Facility 6500 Allentown Rd, Camp Strickland Funeral Services, Springs,MD 23a. Patt1. Enter the lisease, mem shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ anemia iristerus rocigulopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed failure metaballe acio shock 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Prostate concer. Rheumothoran perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mousina

State Registrar

DHMH 17 Rev 1/2001

7503 SURRALLS Rd CLINTON, md 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ARSHA VANIKARMD

31. Date filed (Month, Day, Year)
-MAY 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 5/12/08 per FH, qc 1 - State Registrar Amended #14; Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1511 05-06-2008 JOYCELYN PATRICIA SIMON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Date of Birth (Month, Day, Year) 10-27-1952 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🔀 F 55 Guyana, S.A. Director 219-11-7806 Usual Residence of Deceden with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10h Counts 10a State r then "naturel", or items 23a or 28a-f ehover the Medical Examinar must be notified at #FRYes 2 □ No Director Cheverly Prince George's Marvland 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number USA 20785 3003 Hospital Drive Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: USA 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Industry Nurse Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inent of Heelth and Mental in it is ant: If item 27 is marked o Shelia Weeks Ovid Grev ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5709 Nicholson Street Riverdale, MD 20737 Elnora Andries/sister other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of Primportant: If Ita eny Injury or ot once. 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 05-12-2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Euro 22. Name and Address of Facility mo1246 Cedar Hill FH 4111 PA Ave. Suitland,MD 20746 Welson ac Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adrivation Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 KNo Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 2€ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medicai Certification: Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DEVORE MA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 2 2000

32. Registrar's Signature

08-03663 Lawanda Smallwood

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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				Certificate	of Death			Reg. No.		4-3
led	Physicia lical Exami	ın/	1. Decedent's Name (First, Middle,Last)  Lawonda Smallw	boor			2. Date of De Month May 13,	2008	Year	3. Time of Death 1634 hrs
			4a. Facility Name (if not institution, give street and number) 5421 16th Avenue T-2	ساباليك	4b. City, Town, or Hyattsville	Location of	Death		c. County of D Prince Geo	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In )	yrs. last birthda	Months Day		24Hrs. 8. Date of I		IF	Birthplace (State or preign Country diana
	Director		Usual Residence of Decedent	City, Town or L	Yrs	<u> </u>	10720			10d. Inside City Limits
	. A	ō	MD Prince George's	Hyatt	sville			10g Cit	tizen of What	1 Yes 2 X No
)	he Mary or 28a- iffed at	Director	10e. Street and Number 5421 16th Avenue Apt. 7		2078				USA	
2017	hours after death with the Maryland 'natural', or items 23n or 28a-f show Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2   Married   Marri		3. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, I	n? ( Specify Yes or Puerto Rican, etc.)	No-	14. Race - A White, e Specify:	merican Indian, Black, tc. Black
		ā	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dec	Yes 2 X No cedent's Usual Occupa ing most of working life	tion (Give ki	ind of work done	16b.	Kind of Busin	
	2 , 4	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2		Banking			. I		rust Bank
			17. Father's Name (First, Middle, Last)	<del></del>			Name (First, Middl			
	t de la	То Ве	Bernell Williams  19a. Informant's Name/Relationship (Type, Print )	19b. N	Mailing Address (Stre	et and Numi	neva Sm ber or Rural Route I	ALL V	City or Town,	State, Zip Code)
	e, MD 21 1 and 2 should Health and Me item 27 is ma r traumatic ex		Sarah Smallwood/Aunt		534 Alle:		South Date	Bend 200	d , Ind	iana 46616 ity or Town, State
	W _ H := u		1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Othey Specify:	crematory	or other place) and Cem.					Bend, Indian
b	Baltimor permit. Pages Department of Important: It		21. Signature of Funeral Service Licensee		PHILIP D	RINZ	ALDI FUN	IERA	L SER	VICE, P.A.
Ė	Physician /Medical		234. Part I. Enler the disease, or complications that caused the failure. List only one cause on each line.			g, sould as ca	ardiad-or-frespiratory	Pakrett,Vs	Modok, or coe <u>p</u> u	Between Onset and Death
	aminer		Immediate Cause (Final disease or condition resulting in death)  a. Cardiac ar  Due to (or as a consequence)		.a					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C.	ence of):						
	nted d ansit	Examine	events resulting in death) Last  Due to (or as a consequence)							
	760, icate be executed sphysician and the burial - transit	ledical	X UNPENDED X AMENDED #1 as 23a, PII, 2	s noted 7,perME	per ME g8 ,g881 7/11	82 8/ ./08 T	11/08 TT T	- 6	and not of	la livera
	68 certif	ician/Me	IF FEMALE: 23c. If yes, outcome of	of pregnancy 2	Fetal death				23d. Date of d Month	Day Year
	that the death certiff of by the attending detached for use as:	Physician	1 Yes 2 No 9 ✓ Unknown g Unknown  Part II. Other significant conditions contributing to death but	it not resulting	in the underlying caus	e given in Pa				oute to the cause of death?
	ires that signed b		Acquired immune deficienc				1			Probably 4 Unknown
	cords law requires been 2 should	ete	history of hypertension				\	Was an autopsy performed Yes 2	<u>d</u> ? de	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
	of Vital Reccing Physician: The law After this certificate ha	ပိ	25. Was case referred to medical				(Check only one)			
	f Vital Physician: er this certif	To B	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury		patient 3 DOA	njury at Worl	Nursing Home \$		injury occurre	
	nding   nth.	ig l	1 X Natural 5 Pending (Month, Day, Year)	'		Yes 2				
	Divisic Ial or Atte rs after des al Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	/ - At home, far	m, street, factory, offic	e building, e		ion (Strewn, State		er or Rural Route Number, City
	Division of N To the Hospital or Attending Ph Within 24 hours after death. To the Founeral Director: After t	edical Ce	29a. Certifier 1 Certifying Physician: To the best of my king one) 2 ✓ Medical Examiner: On the basis of examiner:	nowledge, deat lation and/or in	th occurred at the time vestigation, in my opin	, date and plion, death o	lace, and due to the courred at the time,	gate and	i piace, and u	de to the cause(s)
_		15	29b. Signature and title of certifier			ense number	r		_	ed (Month, Day, Year)
1	Liped	1	Don moline, no		0.	C.M.E. ———			иау 14, 20 ————	
	3		30. Name and address of person who completed cause of dea Donna M. Vincenti, MD Assistant Medical		111 Penn Stre	et, Baltim	nore, MD 2120	1		
		State	TV L L L L L L L L L L L L L L L L L L L	Signature	Courte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Herbert Smith /Medical 1274 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ENINSULa Regional CTR. Dalesbury Wicomico Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 XM 2 ☐ F Hours Min. 251-34-9506 Director 81 4/20/1927 unknown Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. Director 1 XYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Times Square 21801 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No þ Specify 3 ☐ Widowed 4 ☐ Divorced Specify: black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 poultry plant worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Senkbeil/guardian 105 Times Square, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 5/7/08 Salisbury, MD 21. Signature of Funeral Service Lin 2. Name and Address of Facility Holloway Funeral Home Professional Association Kell 1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injuly that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami attending physiclan and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day signed by the a 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCHIZO PHREMA, SCIZURE DISORDER cate has been si page 2 should 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1□ Yes 2 No 1 ☐ Yes 2 ☐ No Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 27. Manner of Death spital or Attending P nours after death. neral Director; After t filled in by the funera 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 763433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOSH1 106 MILFORD ST, \$ 504B; SAUSBURY 32. Revistrar's Signature 31. Date filed (Month PAYYEU 8 2008

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02-2008 Month Thomas Leon Stevenson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Salisbur HOSPICE at lo4220. the WICOMICO If Under 1 Year | If Under 24 Hrs | Months | Days | Hours | Min. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1X M 2 □ F 213-44-0871 Dec 7, 1946 NY Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 Mill Pond Lane, Apt. 416 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Psychiatric Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leander N. Stevenson Marian F. Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara F. Miles/sister 10701 Jones Creek Circle, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) MD Veterans Cemetery 5/12/2008 Hurlock, MD 21. Signature | Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 0000 1618 West Road, Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRTASTATIC CARCINOWA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a y leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown

**Physician** /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

10a, State

MIT

Director

Funeral

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Completed

Be

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Homas

burial-trans the as

Examiner Physician/Medical þ Completed Be ဥ

25. Was case referred to medical examiner? 27. Manner of Death

Certification:

Medical

attending physician use Po detached the should be has certificate this funeral To the Hospital or Attending Phentin 24 hours after death.
To the Funeral Director. After the completely filled in by the funeral : After t

4 ☐ Homicide 29a. Certifier

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ 1 ☐ Yes

1 Natural 2 Accident

3 ☐ Suicide

5 ☐ Pending investigation 6 ☐ Could not be determined

Hospital:

1 ☐ Impatient

28a. Date of Injury (Month, Day Year)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? Injury

2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

POBOX 1737 SAUSBURY MY 21802

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an

26. Place of Death Check onl one)

autopsy performed? Yes

28d. Describe how injury occurred

29c. License number D005 8410 29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Human

31. Date filed (Month, Day, Year) MAY 0 8 2008

3

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Jampson /Medical 2008 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Che Sa Pea Ke 5. Social Security Number 6. Woods Center Dorchester **Funeral** 6. Sex 7. Age (In yrs. last birthday) 79 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 😿 F Days JAn. 10, 1929 Maryland Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~." any injury or other traumatic avoid. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Campridge 1 es 2 No Dorchester 10e, Street and Number 10g. Citizen of What Country? Drive 15h 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Specify: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sea Food Industry rocessing Line Worker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ward Jones Mary Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sampson 20b. Place of Disposition (Name of cametery, crematory or other place) Cambridge MD. 21613

20c. Location - My Town, State Arthur 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/08 hompsontown lengters 5/11/08 the 22. Name and Address of Ficility Henry Funeral Home, P. A. ^ 4 □ Donation 5 □ Other (Specify) thompsontown, MD. 21. Signature of Funeral Service Licensee anelle 04 510 washington St. Cambridge, MD. 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer's Physician years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached f of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertension 1 Yes 2 No 3 Probably 4 Unknown Completed rabete mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 22No certificate 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

's Signature

Regis

610 Dutchmans Lane, Easton, MD 21601

30. Name and address of person who completed cause of death (I 23a) (Type, Print)

Crowless

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY **Physician** 2008 MARJORIE LOUISE SMITH 3:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON REEDERS MEMORIAL HOME BOONSBORO 8. Date of Birth (Month, Day, Year) JUNE 3, 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 X F 028-12-4856 MASSACHUSETTS 1925 Director 82 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at 1 X Yes 2 □ No Directo BOONSBORO -28a-f MARYLAND WASHINGTON 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ö must be 23a 21713 Funeral 141 S. MAIN STREET U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 'natural", or items 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner any once. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than " Elementary/Secondary (0-12) 12 College (1-4or 5+) APT. COMPLEX MANAGER APT. COMPLEX 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN JAMES CUNNINGHAM ETHEL HARRIGAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 21713 6111 CLEVELANDTOWN ROAD, BOONSBORO, MARYLAND CHUCK KERR, NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/13/08 STAUFFER CREMATORY, INC. FREDERICK, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee BAST-STAUFFER FUNERAL HOME BOONSBORO, MARYLAND 21713 7606 OLD NATL. PIKE BOONSBORO, 23a. Parti Eper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Dovanced physician and is the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No ို 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

or Attending Physician: ours after death. neral Director: A filled in by the fu within 24 hours

To the Funeral

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

4656

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 / 301-432-8470 DR. GHAZALA QADIR

State Registrar

Medical

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2008 MAY **Physician** VIRGINIA ANNA LOUISE SLIFER 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Min. Months Days Hours **Funeral** MARYLAND 1 ☐ M 2 💢 F 26. 1923 MAR. 220-16-1625 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2X No BOONSBORO Directo WASHINGTON MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number marked other than "natural", or Items 23a or unatic event, the Medical Examiner must be U.S.A. 21713 5631 AMOS REEDER ROAD 14. Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify. Specify WHITE Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE DOCTOR'S OFF. REGISTERED NURSE 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fili.
Department of Health and Mental Hit
Important: If item 27 is marked oth
any injury or other traumatic event MARGIE A. BAKER AMOS E. REEDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AMOS REEDER ROAD, BOONSBORO, MARYLAND WILLIAM H. SLIFER, SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STAUFFER CREMTORY, INC.5/15/2008 FREDERICK, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
BAST-STAUFFER FUNERAL HOME, P.A. 7606 OLD NATL.PK.
BOONSBORO, MARYLAND 21713 ouce he distance of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Corebro vascular accident **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a conse Physician/Medical 23d. Date of delivery IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. or Vital Records, by Νο 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy + has performe page 2 No 1∐ Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 No 1 Inpatient 1 TYes P 28d. Describe how injury occurred al or Attending Phys after death.
Il Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Manner of Death Certification: Injury Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar 31. Date filed (Month, Day,

29b. Signature and title

Cappans Rd Boonsbook MD. 217/3 s Signature 32. Regist 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ar Malik

20311

29c. License number

0 44996

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** CLARA ANN SIMMONS 7:45 P M /Medical 4/27/2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 105 LYONS LANE CHESTERTOWN QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □X Director 579-26-6226 84 JUNE 20,1923 PA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location ns 23a or 28a-f show must be notifled at 10d. Inside City Limits MD OUEEN ANNE'S CHESTERTOWN Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 LYONS LANE 21620 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify ģ Specify: WHTTE 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 4 AUTHOR LITERATURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WILLIAM R. THOMAS, JR. BESSIE HUTCHINSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i ELISABETH M. SIMMONS/DAUGHTER 900 MILLTOWN RD. WILMINGTON, DE 19808 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of i Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 4/29/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Archs FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as our cor respiratory arrest, shock, or heart failure. List only one cause on with line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, but Ingle in intercept cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director for as a consequence of Examine law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): physician Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant condition 23e. Did tobacco use contribute to the cause of death? use giyen in Part I. 2 pe Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 Ho has autopsy performe certificate 2 No Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760, Division or Vital Records, Hospital the

completely 2

State Registrar

ca

29a, Certifier

29b. Signature

th (Item 23a) (Type, Print M)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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32. Regis 2008 **APR 29** 

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

IttoMAS GALVW III MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ames

MAY 08

29b. Signature and title of certifier

29c. License number

25/660

29d. Date signed (Month, Day, Year)

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2008

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		•	For Amend Items 2	tate of Maryland 2 <b>3a, 25, 27, 28</b>	d / Depa i-f <b>pe</b>	artment o	of Healt 8 <b>79 0</b> of Dea	th and 1/22/	Mental Hy 08dhb	giene Reg. No.	2008	169	947
	Physici /Medic		Decedent's Name (First, Middle, Last)     HAROLD ROSCOE TAYLO	R					2. Date of De Month MARCH 1	Day	08	3. Time of 5:35 H	
)	Examin		4a. Facility Name (If not institution, give stre SOUTHERN MARYLAND H	The state of the s		4b. City, To	N				County of Death	ORGES	
٠	Funeral Director		5//-40-/059	7. Age (In yrs. I	as <i>t birthday)</i> 81 <sup>Yrs.</sup>	If Under 1 Months E	Year If Ur Days Hou	nder 24 Hrs urs Min	. (Month, Da	y, Year)	9. Birth Cou VIRG	place (State on ntry) INIA	r Foreign
	Maryland -f show iled at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         PRINCE GEO		Town or Lo							10d. Inside Cit 1 X Yes	•
	with the a or 28a	Director	10e. Street and Number  9505 QUEENSWAY ROAD	KGEB CII	LIC IUII	10f. Zip Co				10g. Citize	en of What Cou	ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	•	Was Decedent Ever in U.s Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: NAVY			t of Hispani Cuban, Me	c Origin? ( exican, Pue	Specify Yes or No rto Rican, etc.)	- 14	4. Race - Ameri Black, White, Specify: BL.	etc. ACK	
21215-0036	within 72 h iene. than "natu the Medical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 12TH	ion ompleted) College (1-4or 5+)	(Give life. L	tent's Usual C kind of work of DO NOT use i	done during retired)	most of w	orking		d of Business/Ir  OVERNME		
Maryland 2	should be filed ind Mental Hyg marked other umatic event, i	To Be C	17. Father's Name (First, Middle, Last) ALFRED N. TAYLOR				18. N		ame (First, Middle, TTA ELLIS	, Maiden S			
	and 2 sho ealth and n 27 Is me		19a. Informant's Name/Relationship (Type. ALICE TAYLOR/WIFE	Print)		_			Rural Route Numb JPPER MAF				
Baltimore,	Pages 1 and of the control of the co		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, cirer	sition (Name matory or othe ANS CEN	er place)	03/0	Date D8/2008		ation - City or T		
Balti	permit. Departri Importa any inju		21. Signature of Funeral Service Licensee	eriol				-	.B. JENK) D LANDOVE			HOME	
	Physician /Medical		23a. Part1. Enter the disease or complica shock, or heart failure ist only one immediate Cause (Final disease or condition resulting in death)	Coron	ary	er the mode of Hema	toma	ch as cardi	ac or respiratory a	rrest,		Approximate Interval Bet Onset and I	e ween Death
8760,	Examiner	ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)  Due to (or as a consequence)	ience ofj:		¢.	L.	NAPPROVED BY M	EDICALEXA	MINER		
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c 23c in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome pf pregna 1□Live birth 2□Fetal 4□Pregnant at time of do 9□Unknown	death 3	Ectopic preg Other (spec				23	3d. Date of deliv		Year
rds, P	quires that en signed b uld be deta	þ	Part II. Other significant conditions contri	- · ·	-		se given in F	Part I.		77	e contribute to ] No 3 ☐ Pro		
Division or Vital Records,	: The law requir cate has been si page 2 should	Completed					_		24a. Was auto perfo 1 Yes		24b. Were aut prior to co death? 1 ∐ Yes	opsy findings ompletion of c	available ause of
Vita	ding Physician: Th n. After this certificate funeral director, pag	o Be	25. Was case referred to medical examiner?  1 X Yes 2 1 No	pital: 1 □ Inpatient 2🛣	ER/Outpatier	nt 3□ DOA	Other:		eath <i>(Check only o</i>		□Other (Spec	ifv)	
io uoi	ding I. After funer	ation: T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year) 01/05/2008	28b. Time of Injury Unkno	a	lnjury at Work? 1 ☐ Yes	2 <b>x</b> No	28d. Describe Subjec				
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	To the Hospital or within 24 hours afte Foreral Dir completely filled in	Medical		ian: To the best of my kno r: On the basis of examina and manner stated.									s)
5	To the To the Complex	Me	29b. Signature and title of certifier	ringdy M	MD.		icense num 052999			29d. Date	signed (Month	, Day, Year) 2658	
2	(10)		30. Name and address of person who compaLI RAHIMIAN, MD 10	pleted cause of death (Item	23a) (Type,		CLINI	CON, I	MD 20735		1-1-		
	Sta Registi		31. Date filed (Month Day, Year) MAR 1 2008	32. Registrar's Signa	tue park								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amended line State Registrar per FH/tlv 5/9/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2008 May 8, 1:45 Lorraine Virginia Taylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 96 -9, 1912 Maryland Director 212-16-3222 Jan. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 20872 26109 Woodfield Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. þ 3 Widowed 4 □ Divorced "natural" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental Harvey Lansdale Watkins Bertie Olivia Bellison ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health; 26109 Woodfield Road, Damascus, Maryland Tamara Taylor Newman, daughter 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 05/13/2008 ortant: If if in injury or c tment of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Damascus Methodist Cemetery Damascus, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home Depart Import any in once. 21. Signature of Juneral Service Licensee 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONITIS **Physician** ASPIRATION disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) DIFF The law requires that the death certificate be executed physician and the burial-transit Colit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Day in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 17 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

leral Director: A
filled in by the fu death. 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D54418 8,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTGOMERY GENERAL HOSPITAL O- MD DEWUN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 9 2008

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year **Physician** 02:00P 5/1/2008 KATHARINE ALINE SHRILEY THOMPSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESTERTOWN CHESTERTOWN NURSING & REHAB If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days Months Min 1 M 2 X F Director 219-03-5713 93 7/24/1914 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 1 XYes 2 No Directo CHESTERTOWN MD KENT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21620 408 MORGNEC RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. þ WHITE 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSES AID HEALTH CARE 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM L. SHRILEY MABEL L. GROVES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7129 QUAKER NECK RD. CHESTERTOWN, MD 21620 JAMES W. THOMPSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 5/5/2008 CHESTERTOWN, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service License 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tevio 3 derotec ardioves au so years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 X No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 25. Was case referred to medical examiner? 26 Place of Death Check onl one Be

**Physician** /Medical Examiner

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

"natural", or Items 23a or 28a-f show sdical Exa⊡lner must be notified at

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permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other these

and the burial-tra attending physician for use as the hirial signed by the a has page 2 certificate this completely filled in by the funeral After

requires that the deeth certificate be executed

The law

Physician;

or Attending

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To the Hospital o within 24 hours aft To the Funeral DI

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Division or Vital Records, P.O. Box 68760,

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3□ DOA 1 🖂 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27...Manner of Death 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1/2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature endettie of certifier

640 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Wa3hm Are scesion K. mo 516 LOSS Day, Year) 32. Registrar's Signature 31. Date filed (Month,

State Registrar

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL **Physician** 12008 10:50P MONIQUE WASHINGTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES MEDICAL CENTER PLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-06-1970 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Min Country) 1 □ M 2 □39 Yrs Wash.,D.C. 37 Director 578-82-4671 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1包Yes 2□No Director Maryland | Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3689 Kempsfordfield Place 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛱 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 hand Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sahverrhett Washington Sharon Addison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trai Parris T. Dunbar/husband 3689 Kempsfordfield Place Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hawes Family Cemetery 05-03-08 Kelly, North Carolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Mary Hedgman MO1374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** encephalopalle /tnoxic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Complication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical as 1 IF FEMALE nse 9 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of autopsy prior to completion death? performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<mark>⊡</mark> No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

signed by the attending physician and I be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, this death. al or Attend after death

Baltimore, Maryland 21215-0036

Pages 1 and 2 should I

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To the Hospital o within 24 hours af To the Funeral D

State Registrar

DHMH 17 Rev 1/2001

Medical

SALFEH AHMED 31. Date filed (Month, Day, Year) MAY 1 2 2008

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D-0062773

5 CARRETT ST. P.O. BOX 1070 LA PLATA, MD. 20646

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician d00<u>:11</u> Henry Joseph Wolyniec May 5,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6913 Woodland Avenue Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 5, 1918 **Funeral** Months 89 077-16-8848 Yrs New Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Counfy 28a-f show Yes 2 No r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notified MD Montgomery Takoma Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6913 Woodland Avenue 20912 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1粒 Yes 2□No If Yes, Give 1945 11. Mantal Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Beverage Co. 12 ith and Mental Hygier 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antoni Wolyniec Pauline DuBina 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Amelia C.Wolyniec/Wife 6913 Woodland Avenue Takoma Park, Md 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) Chesapeake Crem 5/8/2008 Beltsville, Md Funeral Service Licen PHYTETPAODS RITHALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by coronary artery disease 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 25. Was çase referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 H Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕇 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 70 29b. Signature and title of certifier

State Registrar 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Resstrar's Signature

ENEUR

MD

9 2008

David Brill

D36601

7901 Maple Avenue Takoma Park, Md 20912

May 7,2008

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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JATSON **Physician** OLIS AM 2008 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🖫 F Yrs. MY 214-34-8034 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at 1 XYes 2 No Worcester Berlin Funeral Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Quail Run Apts., Apt. 14 21811 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3⊠Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Poultry Pages 1 and 2 should be filled wirtnent of Health and Mental Hygien trant: if Item 27 is marked other th jury or other traumatic event, 12 Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Thomas Laura Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Danny Thomas, Sr./son 518 N. Curlew Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or 4 □ Donation 5 □ Other (Specify) New Bethel UMC Cem 5/8/2008 Berlin, MD 21. Signature of Funeral Service License 22 Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD Wasser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Squamous Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 MUnknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes l lirector, page 2 s 2 X No 25 No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Dale of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 ☐ Pending 1 □ Yes 2 □ No investigation To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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Baltimore,

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Watson, 214-34-8

and address of pirson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (MoMAYV, 0=8 2008

06 e egistrar's Signatura D0050826

9733 Healthway Dr Belin MD 21811

		·	For State Registrar	State of Maryland		rtment of H		Mental Hy	giene Reg. No.	2008	169	954
<i>3</i> -	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of	
	/Medic		Ruth Elaine Ward  4a. Facility Name (If not institution, give sti	reet and number)		4b. City, Town, or	Location of Dea	May 7,		County of Deat	1:10 h	P <sup>M</sup>
	Examin	er	Collingswood Nursin			Rockville				ntgomer		
.w. =	Funeral		Social Security Number     6. Sex	7. Age (In yrs. la		If Under 1 Year   Months Days	If Under 24 Hr Hours Mir	n. (Month, Da	rth a <i>y, Year)</i>	9. Birt Co	hplace (State o. untry)	r Foreign
19.	Director		216-22-9889 Usual Residence of Decedent	92	Yrs.			Dec. 1	5, 19	15 Mar	yland	
	yland how at		10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside Cit	
	ne Mau 8a-f sl ptified	Director	Maryland Montgomery	North	Beth						1 🗆 Yes	2 📉 No
	a or 2		10e. Street and Number			10f. Zip Code				en of What Co	untry?	
	ms 23	Funeral	10500 Rockville Pik	2. Was Decedent Ever in U.S.	i. 13. V	20852 Vas Decedent of His f Yes, specify Cuba	spanic Origin? (	Specify Yes or No	USA o- 1	4. Race - Ame		
9	after or Ite	/ Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		r yes, specify Cuba □ Yes 2 <b>X</b> No		erto Hican, etc.)		Black, White Specify:	e, etc.	
5-0036	be filed within 72 hours after death with the Maryland that Hyglene. 3d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 🕅 Divorced  15. Decedent's Educa	Year or Dates:	16a Decec	lent's Usual Occupa	ation			Whi		
75	in 72 in "na Medic	Completed	(Specify only highest grade  Elementary/Secondary (0-12)	completed)  College (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired,	luring most of w )	rorking	TOD. IXII	of Business/	moustry	
212	filed with Hygiene <b>rther tha</b>	Com	7	College (1-401 5+)	homem	aker				home		
Maryland 2121	eve eve	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		Surname)		
Ĕ	should be and Mental s marked o	ဥ	Harvey E. Etchison 19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailin	g Address (Street a		lae Hawki Rural Route Numb		Town, State, 2	Zip Code)	) E O
	es 1 and 2 should of Health and Mer item 27 is marke other traumatic		Bettie Jean Hessie,	1.0		Rockvill						
Baltimore,	es 1 a of He of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pla		sition (Name of natory or other place		2/2008	·-	cation - City or		
Ĕ	permit. Pages Department of I Important: If ite any injury or of once.		4 □ Donation 5 □ Other (Specify)	C1ar	ksbur	Methodi	st Ceme	terv	Cla1	ksburg	, Maryl	and
Ba	permil Depar Impor any in		21. Signature of Funeral Service Linensee	3		Name and Addres 401 Ridge					uneral 20872	Home
	<i>₩</i>		23a. Part1. First the disease, or complication	ations that caused the death.						Lyland	Approximate	е
W.	Physician		shock or heart failure. List only one Immediate Cause (Final disease or condition	Cerebrovascı	ılar D	icasca					Interval Bet Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence		ISCASC						
36	LAAIIIIICI	Į.	Sequentially list conditions, if any, leading to immediate	Hypertension Due to (or as a consequence)								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Dementia	51100 diji					d-1		
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence	ence of):							
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical	d.									
Box 6	leath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome pf pregnar	су				,	3d. Date of del	iven	
ĕ	death e atter	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other <i>(sp</i> ec <i>ify)</i>				Month	•	Year
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ecords,	w require	eted						24a. Was	- 5		utopsy findings	
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	ian: T	BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only		1 □ Yes	2□No	
or <	Physician: r this certific ral director,	၉	1 ☐ Yes 2 📉 No	spital: 1   Inpatient 2   E			4ALI Nursing	Home 5 ☐ Res			cify)	
	ding Phys h. After this funeral dir	ion:	27. Manner of Death  1 ₭ Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □	/at <br Yes 2 □ No	28d. Describe	how injury	occurred		
Division	Attending or death. ector: After by the funer	ifica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of injury - At hor	ne, farm, stre					i Number or Ru	ural Route Num	iber,
=	= 5 te d	Certification:	4   Hollicide	building, etc. (Specify,				City or 10	iwn, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my knower: On the basis of examinati and manner stated.	rledge, death on and/or in	occurred at the time vestigation, in my operation, in my operation.	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s	;)
	To the within To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date	e signed (Mont	h, Day, Year)	
			I ofhich "	0-1		D09303	3		May 9	, 2008		
-	2		30. Name and address of person who com									-
	Sta	te	Rita Ghosh, MD, 148	32. Registrar's Signati	ıre		ckville	, Maryla	nd 2	20850		
	Registr		MAY 0 9 200		K A	never						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Alvin Leroy Whitney 11:05 A M 2008 May 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Long View Nursing Home Manchester tf Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St (Month, Day, Year) | Aug. 30, 1917 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 ☐ F 215-09-3103 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show eny injury or other traumatic event, the Madical Exercise. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Carroll County Manchester Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4927 Kern Road 21102 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by Specify: white 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) supervisor ice cream plant 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Alvin O. Whitney Gertrude Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Whitney - son 4927 Kern Road Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State May 10, 1 

Burial 2 □ Cremation 3 □ Removal from State Lineboro Cemetery Lineboro, Maryland 4 Donation 5 Dother (Specify) 2008 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 urv 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Finat disease or condition resulting in death) Atheroscleratic cerebral vascular Physician yeavs /Medical Due to (or as a consequence of): Examiner Sequentiatly list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physicien and shed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by d Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Oid tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No To the Hospitel or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3[] DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After ospitei ...
4 hours after dea...
- real Director: After 1 Naturat 5 Pending tniury 1 Yes 2 No investigation 2 Accident the Funeral Directory filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WJL V37573 2008 30. Name and address of person who ted cause of death (ttem 23a) (Type, Print) Jef Usdis 25 Main S). MD 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Division of Vital Records, P.O. Box 68760,

		-	For State Registrar	State of Marylar	•	artment of He tificate of D			jiene	800	16955
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Mary Patricia Win	ters					06, 20		1:45 P. M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or I	ocation of Death			unty of Death	
			St. Vincent Care			Emmit:				rederic	
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Cou	
	Director	-	212-30-9317	M ZQI	73 Yrs.			May 29,	1934	Mar	yLand
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Lo	cation					I Od. Inside City Limits
	/anyl	ō	7 1	. 1	T	I					1x Yes 2 □ No
	28e-	Director	MD Freder:  10e. Street and Number	ıck	Emmits	10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	death with the Maryland ms 23a or 28e-f ehow r must be notified at					21727			1	U.S.A.	
	ns 2	Funeral	335 South Seton A	2. Was Decedent Ever in L	J.S. 13. \	Was Decedent of His	panic Origin? (Spe	ecify Yes or No-		Race - Ameri	
	r iter	Ē	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No		f Yes, specify Cuban		Hican, etc.)		Black, White,	etc.
12-003p	be filed within 72 hours after death with the Marylan last Hygiene.  I all Hygiene.  I other than "natural," or Rems 23a or 28e-f show other than "natural," or Remissaring event, the Madical Examinar must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 ☑ No	Specify:		Sp	рөсіfy: Whi	te
၃ ဂ	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa- kind of work done do	tion uring most of work	ing		of Business/In	
Z	within 72 ene. than "na	nple	Elementary/Secondary (0·12)	College (1-4or 5+)	life. L	DO NOT use retired)			Relig	glous C	ommunity f Charity
7	Hygier Hygier other th	S		College 5+	Nu		18. Mother's Name				1 Gharity
and	be fill dot H	Be	17. Father's Name (First, Middle, Last)					l Elizab			
	should be ind Mental marked o umatic eve	은	John Edward Wint		10h Maille	ng Address (Street a					Code)
Mary	C/ cg = 6		19a. Informant's Name/Relationship (Type Mother S	uperior		,					21727
	1 and Health em 27 ther t	1	Sister Camilla Ha			South Set		le, Emmi Date		tion - City or T	
و	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ R	emoval from State S	rovinci	sition (Name of Paley ogother place Lal House	"   5/10	/2008	Emmi	tsburg	, MD
Baltimore,	rtant njury	1	4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		22	Name and Address	s of Facility M	vers-Dir	rbora	w Funei	ral Home
n n	permit. Pages Depertment of Important: If it any injury or o		- Austi R. I	Subon	<b>&gt;</b> 2	210 W. Mai	n Street	, Emmit	sburg	, MD 21	727
ı			23a. Part1. Enter the disease, or compli-	cations that caused the dea	th. Do not ent	er the move of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Consi	100	a Thru					Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		1 /	Jh.				
	Examiner		Parametically list expellings	Plasm	$\alpha$ c -1	Te 1.	caker	mia			1 yacı
	D =	ner	Eaguantially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of): [	, 1	elomo				9
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as I conse	Ple	VII e	Roma	2		-	1 years
Ď,	death certificate be executed e attending physicien end ed for use as the burial-transit		1	Due to (or as a conse	q ence or,						
09/8	physi the t	dical	d								
ک ک	leath certific attending pl	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregr	nancv			430	23	d. Date of deliv	(ADV
X R R	atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)			20	Month	Day Year
o.	the d	ysic	1 □ Yes 2√2No 9 □ Unknown	9□ Unknown							
J.	The law requires that the de sie has been signed by the a bage 2 should be detached t	4	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
Vital Records,	uires sigr Id be	d by						101	res 2/2	No 3□Pro	bably 4 □Unknown
Ö	w requir been si should	Completed						24a. Was	an	24b. Were aut	opsy findings available
Ä	he lav e has	ᇤ				····			rmed?	death?	mpletion of cause of
<u>a</u>		ပိ	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	2 20 No	1 🗆 Yes	2L NO
	s cert lirect	8	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	A	ome 5□ Resid		Other (Spec	ifv)
Ö	Attending Physician: or death. ector: After this certific by the funeral director,	n: To	27. Manner of Deat	28a. Date of Injury (Month, Day Year)	28b. Time o		at	28d. Describe I			,,
<u>0</u>	th: -: Afte	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		res 2 □No				
Division of	il or Attending Phy effer death. I Director: After this d in by the funeral d	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (S City or Tox		Number or Ru	ral Route Number,
ā	s efte	Certification:	4 _ Homoldo	building, etc. (Spec					, , , , , , , , , , , , , , , , , , , ,		
	To the Hospital or Attandi within 24 hours effer death. To the Funeral Director: A completely filled in by the fi	edical (		sician: To the best of my kr							
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date	signed (Month	, Day, Year)
	F ¥ F 8		Bou tall	rembel- So	2012	UPD HO	04403	· h	00-	06-7	908
	Mar		20 Name and address of	moleted course of death (1)	am 23a\ /Tua-	Print)	171-0	£ 112.	1110	12 57	Real
	1		30. Name and address of person who co	DETAIL DET -	DO TI	ERNO	# 1,11	1. 18/	1	111	D 21121
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		Uma	100	uy,	VVC	(-)
	Regist			2008 Elseva	· K	Sparts )					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene GQL. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:50a M 05 2008 Preston Wade Leroy May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 16515 Accolawn Road Prince Georges Accokeek 8. Date of Birth (Month, Day, Ye, 05/27/ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F 1948Washington DC 59 212-54-3918 Director Usual Residence of Decedent 10c. Cify, Town or Location 10d. inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland Prince Georges Accokeek 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once. 16515 Accolawn Road 20607 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No if Yes, Give Year or Dates: 1968-70 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Skilled Laborer Self-Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl John Leroy Wade Savoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2065919a. Informant's Name/Relationship (Type. Print) 40575 Kavanaugh Rd.Mechanicville,Maryland Conrad Young/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 5/14/08 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Filmeral Service Lice 191 20605 Aquasco Rd. Aquasco, Maryland 20608 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTETIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 No ospital or Attending Physician:
hours after death.
uneral Director; After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MARHN D. U. 31. Date filed (Month, Day,

MAY 0

9

Greenbelt MARY LAND 2077 U

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Year 2008 4c. County of Death Day Month **Physician** 17:14PM Joseph F. Young, Sr. May /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. **1** 2 □ F Months 65 579-54-1916 06-12-1942 Wash. D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits TX Yes 2 No Director Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12615 Cambleton Drive 20774 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married ★★Married 1 ☐ Yes 2 ☐ No Specify: **Black** þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Computer Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Young Mary Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1\,2615\,$ Cambleton Drive Louise D. Young (Wife) Upper Marlboro, Maryland 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cem. 4 Donation 5 Other (Specify) 05-13-2008 Washington, D.C. Raiph Williams Funeral Service 1813 Potomac Ave., SE; Wash., D 20003 Potomac Ave., SE; Wash., DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nun Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 2]\No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XVo 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury **DEN**atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician: The law requires that the death certificate be executed and the burial-tran Division or Vital Records, P.O. Box 68760, physician ģ s been signed b should be deta certificate has page 2 director, After this funeral or Attending hours after deatl filled in by Hospital

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Examiner

omo

Baltimore,

within 24 hours a Registrar

State

31. Date filed (Month, Day, Year)

MAY 0 9 2008

4 ☐ Homicide

29b. Signature and title of certific

29a. Certifier (Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18P2MA-7525 Green way Center Drive, Green belt, MD 20770 32. Registrar's Signatur

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physician	
/Medical	
Examiner	

Fun Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If them 27 IS marked of other than "natural", or items 23a or 28a-f show any Injury or pither traumatic event, the Medical Examiner must be mortified at any Injury or pither traumatic event, the Medical Examiner must be mortified at

Baltimore, Maryland 21215-0036

**Physic** /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 behaviors after death.

To the Fuer all pirector: After this certificate has been signed by the attending physician and control transfer and dispersed signed and death of the property of the prope

Division or Vital Records, P.O. Box 68760, Rep.

		1 - State Registrar			Cei	rtificat	e of L	Death			Reg. No.	2008	16959
Physicia /Medic		1. Decedent's Name (First, Middle MARIE ROSE	e, Last) ATKINSON							2. Date of D Month May 2		008 Year	3. Time of Death 1:10A M
Examin	1.0	4a. Facility Name (If not institution William Hill Ma	-	mber)		Eas	ston	Location				County of Dear	
uneral irector		5. Social Security Number 212-30-3739	6. Sex 1 □ M 2 🙀 F	7. Age (In yrs. 99	last birthday) Yrs.	If Unde Months	Days	If Under Hours	Min.	8. Date of B (Month D June 7.	irth <sup>(2ay,</sup> 1 <sup>y</sup> 6ar)	9. Bird Mar	hplace (State or Foreign ylland
i-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Talbo			y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2/1/No
3a or 28a st be not	Funeral Director	10e. Street and Number 501 Dutchman La	ıne			10f. Zij	Code 2160	1			10g. Cit	izen of What Co	ountry?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	ried Armed Fo	ve		Was Dece If Yes, spe 1 ☐ Yes		ispanic Ori an, Mexical Specify:	igin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Ame Black, Whit Specify.Whi	e, etc.
the Medical	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12	nt's Education st grade completed) College (		16a. Dece (Give life.	kind of wo DO NOT u	al Occupa ork done d ise retired	ation during mos l)	t of worki	ing		etail	/Industry
rked othe tic event,	To Be C	17. Father's Name (First, Middle, John Joseph Nah						18. Mothe		(First, Middl Marga		surname) Rosenbe	rger
n 27 is ma er trauma		19a. Informant's Name/Relations Mrs Margaret Ca		DTR ll <b>a</b> zzolo	i	•					Maryl	and 216	01
rtant: If iten njury or oth		20a. Method of Disposition  ### Burial 2 ☐ Cremation  ### Donation 5 ☐ Other (S		Ctata	Place of Disposemetery, created Holy	Rede	other plac eemer	. 1	May 3	30, 200	8 B		e, Maryland
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sician ledical		723a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause on	caused the deat	diae	der the mo	1	g, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between Interval Between
miner	Jer	Sequentially list conditions, if any, leading to immediate	b	(or as a conseq	in S	fem	G	VA					48 hers
ician and burial-transit	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):	wh	tun	der	<b>\( \)</b>				
phys s the	dic		d										
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐Live	itcome pf pregna birth 2 □ Feta nant at time of d	ıl death 3[	⊒Ectopic p ⊒ Other (s						23d. Date of de Month	livery Day Year
n signed b Ild be deta	δ	Part II. Other significant conditi	ons contributing to a	leath but not res	ulting in the u	nderlying	cause give	en in Part I	l.		tobacco		o the cause of death? robably 4 □Unknown
icate has bee ; page 2 shou	Completed	Deme	Stoge notes al	Stered y here	Dye	Typ	le			24a. Wa aut pei 1⊟ Yes	topsy rformed?	prior to death?	utopsy findings available completion of cause of s 2 □ No
certifi	Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	land to a C	50/0 to #	10	Othe	or:		n (Check only			
After this funeral di	tion: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pendir	28a. Date (Mor		28b. Time of Injury		28c. Injun Work	4 🗷 Ni		me 5∐Re 28d Describ		6 □Other (Sperry occurred	ecity)
I Director: d in by the	Certification:	2 Accident 3 Suicide 4 Homicide	not be 28e. Place	e of injury - At ho ling, etc. <i>(Specit</i>	ome, farm, str	reet, factor	ry, office			28f. Location City or T	(Street ar own, State	nd Number or R e)	ural Route Number,
he Funera	Medical C		ng Physician: To th Examiner: On the I and mar										
To ti	Ž	29b. Signature and title of certifie	lleam	HWO	od N	71) 29	DOS	e number			29d. Da	ate signed (Mon	th, Day, Year)
7		30. Name and address of person William	H Woods J	Ir Md 5	01 Dut	chmar	n Lan	e Eas	ston	MD 216	502	/	
Sta Registr		31. Date filed (Month, Day, Year, MAY 2 7 2	008	Registrar's Signa	ature								

Amend Item: 8 per F H (1-879) Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 17, 2008 Year 11:45 p **Physician** Margaret Anderson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** Randallstown Northwest Hospital Center Birthplace (State or Foreign Country)
 Maryland If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth Mar . 23 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. 1 □ M 2 🗙 F Mar 26, 1944 212-44-0015 64 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No N/A Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21206 3521 Flannery Lane Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 Specify: Specify þ Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiente Important: If item 27 is marked other the any injury or other traumatic event, the once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Mildred McCloud Ollie McCloud ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3521 Flannery Lane Baltimore, Maryland 21206 Alvin Anderson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/27/08 Owings Mills, Md. Garrison Forest Veterans Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Funeral Service Licensee 21. Signatu e Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, nto cellular Immediate Cause (Final disease or condition resulting in death) **Physician** curcinoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trans nding physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 ☐ Yes 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 21 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No Certification: To 1 Tes this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2☐ Accident nerai Director: / / filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D40854 2008 30. Name and address of person who completed cause of person who cause of pe completed cause of death (Item 23a) (Type, Print) 21202 Bald men Place 149 227 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 3. Time of Death **Physician** Year SUGENE 12:25 PM 2008 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner der 24 Hrs. 8. Date of Birth (Month, pey, Year) Itune Arundel Correctional 5. Social Security Jumber If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 15 M 2□F Days 67 Unknown Director Oll (940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 ZYVs 2 □ No Director Md. N/ABaltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3139 Elmora Avenue 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ◯No Specify Specify: Black ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Odd Jobs Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f and Mental F Willie ဥ Allen Flossie Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 Is any injury or other trau Yvonne Smith 1100 Pennsylvania Ave., BAltimore, Md.21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 □ Burial 2X Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 5/24/08 Catonsville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, PA 1300 Eutaw Place, Baltimore, Md. 23a. Part 1. Ether the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CARDIO-RESPIRATORY Examiner Examiner attending physician end I for use as the bunal-trensit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of) P.O. I signed by the aid be detached for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, ģ 24b. Were eutopsy findings availeble prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 hes neamica 1 ☐ Yes 2 XNo certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 2 1 Yes 25 No hours after death. uneral Director: After this 27. Menner of Deeth 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred t Matural 2 ☐ Accident 5 Pending 1 □ Yes 2 □ No investigation the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 6 To the Hospital o within 24 hours af To the Funeral DI completely filled in to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0062148 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) ATNAFA Maryland House Correction Tessup MD 20194 5 GEDTON M.D. 534 2. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2008 Registrar

DHMH 16 Rev 6/95

		For State	State of Ma		d / Depa		Health a	nd Mental Hy		egible.	10000
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/Medic Examin		4a. Facility Name (If not institution Chesapeake Hos) 5. Social Security Number	pice House	e (In vrs	last birthday)	4b. City, Town, o	ım Heig	Death  this La Date of Bi	4c. C	ounty of Death	
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permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Maryleal Evaninar must be notified at once.	Funeral Director	10e. Street and Number 2002 Phillips 7  11. Marital Status	Terrace, Uni 12. Was Decedent B		S. 13.	10f. Zip Code  21401  Was Decedent of H	Hispanic Origi	n? (Specify Ye's or N Puerto Rican, etc.)	USA	Race - Americ Black, White,	can Indian,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if a y leading to with a late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
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To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical lone)  29b. Signature and title of certifier	Examiner: On the basis or and manner sta			29c. Licen	se number		29d. Date	signed (Month,	Day, Year)
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Physici /Medic		Murrill F. Burch	May.	24, 20	Year	1:44 b w			
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		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,		Approximate Interval Between Onset and Death			
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i Diffe	Certification:	3 Suicido 6 Could not be	e, farm, street, factory, office 28f. Location			(Street and Number or Rural Route Number, own, State)			
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To th within To the compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, L	Day, Year)			
		DSUPNO, Medical three officer 145148		May,	241	2008			
2		(3) Name and address of person who completed cause of death (Item 23a) (Type, Print)  (MP) OSUPNO 2000 West Bultimare Street, Bultimare	10, Mai	yland,	2127	23			
Sta	te	31) Date file (Mooth, Gay, Year) 82, Registrar's Senature		1					

State Registrar

8-03698 Harold Bond

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16964

	1- F	or State	•	Certificate of	f Death		Reg.	No	3. Time of Death
, <sup>∢ □</sup> hysician/	Reg	<u>istrar</u> Decedent's Name (First, Middle,Las	t)				2. Date of Death Month Da May 15, 200	ay Year	0051 hrs
xamine		Harold Edgar Bond			ocation of Death	IVIAY 15, 200	4c. County of Dea	th	
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Funeral	5.	Social Security Number 6. Se	***	In yrs. last birthday)	If Under 1 Year Months Days				ign country) MD
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21215-0036 nold be filed within 7 Mental Hygiene. marked other than ic event, the Medica	اي	Harold Edgar	Bond, Sr.	10b Ma	ailing Address (Str	eet and Number of	Rural Route Num	ber, City or Town, S	tate, Zip Code)
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MD and 2 should be 2 should be 27 is m 27 is aumati		Barbara Bond	- Sister	Zon Place of Div	sposition (Name of	emetery,	Date	20c. Location - Cit	y or Town, State
and and Healt item		20a. Method of Disposition	2 Removal from St		or other place)	1		D 11.	MD
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sician /	ı	failure. List only one cause or							
Examiner	- 1	Immediate Cause (Final disease a. Cardiac arrhythmia or condition resulting in death)  Due to (or as a consequence of):							
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387 rtific ling p	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	at time of death 5				- }	
Box 687  e death certific  the attending p  ed for use as th	.ii	1 Yes 2 No 9 Unkr		5 [	Outloo (1-) 2/				the source of death?
, P.O. Box 687 res that the death certific signed by the attending I be detached for use as the	Physician/	Part II. Other significant condition	ons contributing to de	ath but not resulting i	n the underlying cau	use given in Part I.			ute to the cause of death?  Probably 4  Unknown
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Division of Vital E  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Certification: T	27. Manner of Death  1 X Natural 5 Pence 2 Accident Inver 3 Suicide 6 Could dete  4 Homicide  29a. Certifier 1 Certifying Pence Orne) 2 Medical Example Signature and title of certification.  30. Name and address of person Zabiullah Ali, M.D.	ting stigation at the property of the property	of Injury - At home, fail of my knowledge, deal examination and/or inted.	th occurred at the tivestigation, in my c	ffice building, etc.  me, date and place pinion, death occu- License number  O.C.M.E.	28f. Location or Town e, and due to the coursed at the time, do	ause(s) and manner ate and place, and c	as stated. lue to the cause(s) ed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 4: 11 AM BURION JOSEPHINE 27 2004 MAT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FLEN BURNUE AMNE ARUMBEL BALTIMORE WASHINGTON m Enicon If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 K Months Days Hours MD Director 213.09.6334 88 MARCH 24, 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ntt: If Item 27 is marked other than "natural," or items 23a or 28a-1 show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐Yes 2☐No Director **GLEN BURNIE** ANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or dical Examiner must be r 102 CRAIN HWY # 887 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify: è è 3 ₩Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SPINNER 8 WOOL MILL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 ٩ JOHN THOMAS BURIAN ANNIE REBECCA THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 191 8924 A ERIE AVE. NORTH BEACH, MD 20714 WILLIAM C. BEWLEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5 GLEN HAVEN CEMETERY 5.30.2008 GLEN BURNIE, MD 4 Donation 5 Other (Specify 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. GREGORA M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or whose cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS LIFAR Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical DAYS Examiner CELLULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner DAYS physician and the burial-transit MRINARY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 32 No 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2HNo or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1-Natural 5 Pending investigation 2 ☐ Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Hospital within 24 hours a

BAJGAR BONNUE GETURALE mo 32. Egistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar DHMH 17 Rev 1/2001 Time a 0

Lann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

**ORIGINAL** 

29c. License number

00059190

BALTIMORE WAS HIMEON MED

29d. Date signed (Month. Day, Year)

2008

MA7 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 12 per sa g879 05/27/08dhb

State of Maryland / Department of Health and Mental Hygiene

Amend Items 4a,4b per dr., g879 01/22/08dhb

Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** E 12 08 /Medical 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11314 Ore Street Cumberdand Alleganu If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Hours Months 1□ M 2 F Maryland 88 220 10 4191 11-22-1919 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified of 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 21502 Cumberland 1 ☐ Yes 2☐ No Allegany Director ma 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code NE Cumberland 21502 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 No If Yes, Give Year or Dates: Allegany by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: Whit 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis Minnick Sarah Elizabeth Hughes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11314 Ore Street NE Cumberland, MD 21502 Sara A. Gernat/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/8/08 Anatorku Md 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Ronald S <sup>22</sup> State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Approximate Interval Between Onset and Death Sa. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) YELODYSPLASTIC **Physician** 6 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ OBSTRUCTIVE I)IS ENSE 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☎No 24a. Was an autopsy performed? Yes 22No page 2 s 1∐ Yes or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director. 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division ( 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 16 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 LIVENGOOD MD 912 SETON DRIVE CHIMBERLAND MARYLAND 21502 PAUL TAYLOR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 00 TER 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RANDAUS TOWN EASONS HOSPICE AT Northwest Hospital TIMOR 7. Age (In yrs. If Unde Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2√2 F 006-34-6954 90 Director 08/06/1917 Maine Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or Items 23a or 28a-f show event, the Medical Everning must be notified at Director Carroll Eldersburg 1 ☐ Yes 2 🗓 No MD 10e. Street and Number 10g, Citizen of What Country? 10f Zip Code 6202 Rolling View Dr. 21784 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No þ Specify: 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Alba Mitchell Gertrude Winn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Jean Hutchinson (daughter) 264 Bent Ave, Cheyenne, WY 82007 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 05/22/2008 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Rd, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** er /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least a fact underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit /g/ pie Due to (or as a consequence of) P.O. Box 68760. attending physician law requires that the death certificate be Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 Z No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes the detached g Unknow þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2  $\square$  No 1 ☐ Yes 2 📈 No 1 □ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 6 DOUTE 98 BANICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name

02

2 100 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

and address of person who completed cause of death (Item 23a) (Type, Print)

BORMO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 14 25 PM Robert Blatchley L. May 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 68 Yrs 219-36-2323 4 1940 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show sermust be notified at 1 ☐ Yes 2 X No Funeral Director Baltimore Towson Md. 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò USA 21204 113 Versailles Circle Apt F 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or it any injury or other traumatic event, It at Medical Exacult 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Be Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela Ruckle Blatchley Robert L. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 113 Versailles Circle Apt F Towson, Md. 21204 Mrs. Terri Blatchley/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 5-29-08 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fundal Service License or compile fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. En er the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Cardiac valvular Physician /Medical Due to (or as a consequence of): Examiner YEars Cardiomy path -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner 25 years Physician: The law requires that the death certificate be executed physician and the burial-transit oronary Artery disease Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **☑** No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Morlth, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Registrar's Signature

Union Memorial Hospital

29d. Date signed (Month, Day, Year)

may 22, 2008

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2018. University PKWY

Baltimore, MIS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 21008 **Physician** 10:30AM Elizabeth D. Banes /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death **Examiner** Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🗓 F 181-28-9028 70 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 ☐ No MD Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1207 Stevenson Lane 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify: 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.F. Constellation Elementary/Secondary (0-12) College (1-4or 5+) 12 Foundation Manager 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Patrick C. Delaney Mary Scanlan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Banes, III / husband 1207 Stevenson Lane; Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page: Department o Important: If i any injury or 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 Donation Hilltop Service Corp. 5/27/08 5 ☐ Other (Specify) Towson, MD ineral Service Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** CARDIORESPIRATORY ARREST disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner PULMONARY EMBOLUS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ※ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy Were autopsy findings available prior to completion of cause of death? performed' 1∐Yes 2XNo 2 □ No 1 ☐ Yes

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Box 68760, the use as attending p P.O. detached Division of Vital Records, this After

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Maryland 21215-0036

Baltimore,

iral", or items 23a or 28a-f show Examilier mast be notified at

'natural'

Health and Mental em 27 is marked o

traumatic

item 27

= 6

Be

Medical Certification: To

30. Name and address of pers

tor: After this certificate has been sign the funeral director, page 2 should be 4 hours after death. Funeral Director: / filled in by within 24 hours a completely

25. Was case rejerred to medical		26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 🛣 No		Hospital: 1 ☐ Inpatient 2 🗶	ER/Outpatient 3 De	Home 5 ☐ Residence 6 ☐ Other (Specify)							
2 Accident	Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how injury occurred						
3 ☐ Suicide 6 [ 4 ☐ Homicide	Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factor fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
					e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)						
29b. Signature and title of	of <del>of</del> tilier	290- License number 29d. Date signed (Month, Day									

29931

TOWSON.

MARYLAND

State Registrar

CHRISTOPHE ORENTZ. M. D. R 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE REHABILITATION EXTENDED CAL N/A If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F Months Days Hours Min. Director 87 239-24-1126 NORTH CAROLINA 23 1920 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director MARYLAND N/ABALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 29a or any Injury or other traumatic event, the Medical Examinar miss hen a 1713 HEATHFIELD ROAD U.S.A. 21239 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Xes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 XXes 2 No If Yes, Give Year or Dates: 46/48 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BLACK Specify. <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th grade MACHINE OPERATOR BGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TEAT CARTER ၉ ELLA VINCENT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Mae Carter/Wife 1713 Heathfield Rd., Baltimore, Maryland 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 05-30-08 OWINGS MILLS, MARYLAND ne of Fun and Service Licens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCER, **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed A B Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 (No 1∏ Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

Medical

determined

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

29b. Signature and title of certifier

C 31. Date filed (Month, Day, Year)

MAY 27 2008

29a. Certifier

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

License number

BOULE VARD,

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY Day 3. 20018 4:18A Ronald Thomas Cammarata 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Joseph Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 1 <del>∏</del> M 2 □ F Months Days Hours Min. 64 214-38-8170 MD 3 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 XNo Baltimore Timonium

10f. Zip Code

1∐Yes 2⊠TNo

16a. Decedent's Usual Occupation

Management

20b. Place of Disposition (Name of cemetery, crematory or other place)

METASTATIC PANCREATIC CANCER

3 Ectopic pregnancy

1 ☐ Yes

2 No

5 ☐ Other (specify)

GASTRO-INTESTINAL BLEED

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

21093

(Give kind of work done during most of working life. DO NOT use retired)

Highview Memorial Gardens 5/31/08

22. Name and Address of Facility

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

18. Mother's Name (First, Middle, Malden Surname)

Mary Sorrentino

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2322 Aquilas Delight, Fallaston, MD 21047

Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093

Approximately the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Date

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

Automotive

20c. Location - City or Town, State

Fallston, MD

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

Year

Month

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy 2 No

1 ☐Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

14 Bace - American Indian.

white

Approximate Interval Between Onset and Death

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

1 - For State Registrar

10a. State

MD

11. Marital Status

10e. Street and Number

10 H.Quiet Stream Ct.

15. Decedent's Education (Specify only highest grade completed)

Constant Paul Cammarata

Marie Bonita Cammarata/wife

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

23a. Part 1. Er er the disease, or complications the shock, or heart fail re. List only one cause of

1 ☐ Never Married 2 1 Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12) 12

20a. Method of Disposition

Bryan W.

Immediate Cruse (Final disease or consistent resulting in death)

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

Natural 2 Accident

9 Unknown

IF FEMALE:

17. Father's Name (First, Middle, Last)

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates:

College (1-4or 5+)

Due to (or as a consequence of):

Due to for as a consequence of

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

9 Unknown

CORONARY ARTERY DISEASE

5 Pending investigation

Hospital:

n/a

**Physician** 

Examiner

Funeral

Director

ral", or items 23a or 28a-f shore

"natural" the Medical

than

and Mental Hygiene.

Director

Funeral

Completed by

Be

၉

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

/Medical

Examine and A burial-transi attending physician for use as the buria Physician/Medical the as certificate has been signed by the irector, page 2 should be detached <u>۾</u> Completed Be

I or Attending Physician: The law requires that the death certificate be executed after death. after death.

Director: After this certific filled in by To the Hospital within 24 hours a To the Funeral C Hospital

Certification: To 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND DRIVE. TOWSON. OSLER KHOSROW TARASSI М. D. 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) 7 2008 MAY 2 Market. Registrar **ORIGINAL** 

				State of N	/laryland		rtment of F tificate of		Mental Hygie	ne . <sub>No.</sub> 2 ()	08	169	7
			91	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		Vaar	3. Time of D	eath
		Physicia /Medic		JOHN DAILY CORCOR	AN				May 21	Day 200	08	10:45	A. <sup>M</sup>
		Examin		4a. Facility Name (If not institution, give street and number	r)		4b. City, Town, o	r Location of Deatl	n	4c. County			
				Stella Maris 5. Social Security Number   6. Sex   7.	Age (In yrs. la	ast hirthday)	Timor If Under 1 Year	nium   If Under 24 Hrs.	8. Date of Birth	Ba	1time		Foreign
	Ŀ	Funeral Director		213-30-1824 1X M 2□F	74	Yrs.	Months Days	Hours Min.	(Month, Day, Y Nov. 11,	1933		place (State or I ntry) Land	or orgin
	185	D C		Usual Residence of Decedent					, iovi II,	1/33			
		arylar show d at	ı	10a. State 10b. County		, Town or Loc					1	0d. Inside City 1 ₩ Yes 2	
		the M.	ectc	Maryland N/A  10e. Street and Number	B	altimo	re 10f. Zip Code		100	. Citizen of V	What Cour	Λ	_
		with yard	I Dir	124 W. Franklin Street	Ant 1	306		21201	109				
		death ms 2%	Funeral Director	11 Marital Status 12. Was Decede	nt Ever in U.S			LIZOI Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No-		e - Americ	an Indian,	
	9	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	/ Fu	Armed Force  1 □ Never Married 2 □ Married 1 □ Yes 2 □  If Yes, Give			☐ Yes 2X No	Specify:	to nicali, etc.)	Specify	k, White,		
	21215-0036	ural",	Completed by	3 ☐ Widowed 4 M Divorced Year or Date	s:				1.40		WILL		
	15	n 72 h "nati	lete	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give I life. E	ent's Usual Occup kind of work done OO NOT use retire	oation during most of woi d)	rking	ib. Kind of Bu	isiness/in	austry	
	212	withi giene. r thar the M	mo d	Elementary/Secondary (0-12)  College (1-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4			Salesma		I .	onstru	ctio	n Produ	cts
	b	e filec al Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Ma				
M-1	Maryland	Ment Ment arked aric e	일	John Neil Corcoran				Bess	Dai	-			
5 A	Nar	n and h and rism raum		19a. Informant's Name/Relationship (Type. Print)			•		ural Route Number, (			•	000
	e,	1 and Healt em 2	100	J. Clark Corcoran (brot	20b. PI	lace of Dispos	sition (Name of	ng Road S	Date 20	OLUM, c. Location -		Land 21 own, State	<u> 193</u>
70	JOIL	ages ent of it: If ii y or c		1 ☐ Burial 2 X Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ite		natory or other pla Int Crema	i i	23-08 Ba	-1+ima	100 N	Manari an	a
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	GLE	M-22	Name and Addre	ess of Facility	ZJ=00   Da	37 CTIIO	<u>re, 1</u>	Marylan	1
	ñ	permir Depar Impor any Ir once,		Glore Terrane	-	6	500_York	r_RoadB	Funeral laltimore,	Marv1	and $\_$	21212	
				23a. Part1. Enter the dis ase, or complications that caushock, or heart failure. List only one cause on each	sed the death	. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory arres	t,		Approximate Interval Betwee Onset and De	en
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200	9 xo		/Mec	IF FEMALE: 23c. If yes, outco	me of pregna	nev				00.1 D			
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MAY	S, D	requires that een signed b nould be deta	by P	Part II. Other significant conditions contributing to deat	n but not resu	ulting in the ur	derlying cause gi	ven in Part I.	23e. Did toba			he cause of de	
N	ord	equire en sig ould b	ted t						1 ☐ Yes	2 🕅 No	3 ☐ Prol	bably 4 □Ur	known
	Records	ician: The law requires the certificate has been signed rector, page 2 should be de	Completed						24a. Was an autopsy		prior to co	opsy findings av impletion of cau	ailable
AN	a H	cate h								<b>J</b> Mo	death? 1 □ Yes	2⊠ No	
OR	Vital	Physician: this certificatal director, I	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inp		ER/Outpatien	Ott	hor:	ath (Check only one)				
)R(	ō	Physer this eral di	Tc To	27. Manner of Death 28a. Date of	njury	28b. Time of	28c. Inju	4 E3 Nursing r	Home 5 ☐ Residen 28d. Describe how			fy)	
S	ion	Attending r death. ector; After by the fune	atior	1. Accident 5 Pending (Month, 2 Accident investigation (Month,	Day Year)	Injury		rk? ]Yes 2 □ No					
JOHN	Division	r Atte er dea irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	injury - At ho , etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numb State)	er or Run	al Route Numb	er,
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		To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner	s of examinat								
		ro the vithin of the roughless omple	Med	29b. Signature and title of certifier		11.	29c. Licens	se number	290	d. Date signe	d (Month,	Day, Year)	
		L > L O		> 2 medre V	Uni	WIN	0 0	S 27	1 040	Vay	23	Lg 50	08
		5		30. Name and address of person who completed cause							-	07.00-	
		_		ERNESTINE WRIGHT, M.D.			ULANEY V	ALLEY ROL	AD TIMON	IIUM 1	MD	21093	-
		Sta Registr		31. Date filed (Month, Day, Year) 22. Reg	istrar's Signa	A.a.	e s						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylai Registrar		artment of Healt <i>rtificate of Dea</i>		ntal Hygle Reg.	711118	16973
	Physici		1. Decedent's Name (First, Middle, Last)  SYLVIA  CHWICK				Date of Death Month AY 21	L <sup>Day</sup> 2CO8 <sup>ear</sup>	3. Time of Death 4:00P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME		4b. City, Town, or Locat BALTIMORE	tion of Death		4c. County of Death	
	Funeral Director			. last birthday) Yrs.			Date of Birth		place (State or Foreign
	D	or	Usual Residence of Decedent	ity, Town or Lo					10d. fnside City Limits 1 ☐ Yes 2 No
	Mith the A	al Director	10e. Street and Number 918 PAINTED POST ROAD		10f. Zip Code 21208		10g.	. Citizen of What Cou USA	intry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  2 Married  12. Was Decedent Ever in the Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 XNo Spe	c Origin? (Specifixican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: WI	
Maryland 21215-0036	ilthin 72 ho ne. hen "natur e Medicel	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) HOMFMAKER	most of working	168	b. Kind of Business/I	
d 21	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Manatic e Coi	8 17. Father's Neme (First, Middle, Last)			Nother's Name (F	First, Middle, Mai		ш.	
ylan	should be ind Mental inarked c	To B	MAX HOLTZMAN			ROSE		SCHENKI	
	1 and 2 sh Health and tem 27 Is m		19a. Informant's Name/Relationship (Type, Print) MAXINE KONTOFF / DAUGHTER	918 P.	AINTED POST		TIMORE,	MD 21208	
Baltimore,	Pa ant:		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ALTIMORE,	•				
Balt	permit. Departr Importe eny Injo		21. Signature of Funeral Service Licensee	N & BROS., VILLE, MD					
ı	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a	l stu	1	men f			Approximate Interval Between Onset and Death
	Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						la (com
60,	ificate be executed g physicien and as the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	quence of):					
68760,	ificate g phy as the	ledicai	d						
.O. Box	The law requires that the death certivite has been signed by the attending bage 2 should be detached for use a	Physician/M	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant at time of the pregnant at time at	al death 3	Ectopic pregnancy Other (specify)			23d. Date of delin Month	rery Day Year
٥	quires that t n signed by uld be detai	þ	Part II. Other significant conditions contributing to death but not ve	sulting in the u	nderlying cause given in P	Part f.	23e. Did tobac	co use contribute to	the cause of death? bably 4 ∐Unknown
of Vital Records,	The law requirele has been page 2 should	Completed	Atrial to	b			24a. Was an autopsy performed	d? death?	opsy findings available ompletion of cause of
/ital		BeC	25. Was case referred to medical examiner?			Place of Death (C		1140 112165	2   140
	Phys this ral dir	tion: To	1 Yes 2 No Hospital: 1 Inpatient 2  27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury		280	5 Residence  1. Describe how	e 6  □Other <i>(Spec</i> injury occurred	ify)
Division	Hospital or Attending 24 hours efter death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be building)	nome, farm, str	eet, factory, office	281	. Location (Stree City or Town, S	et and Number or Ru State)	al Route Number,
	To the Hospital o within 24 hours eff To the Funerel DI completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn 2 Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or in	h occurred at the time, dat vestigation, in my opinion,	te and place, and , death occurred	due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	Total Some	W	29b. Signature and title of certified		29c. License numl	21/1		Date signed (Month)	121
_	le '		30. Name and address of person was completed cause of death/life	m 23a) (Type,	Print) 1838	G	iene	Tree	Rd 2100
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Sign	ature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2050PM 2008 Richard L. Dean, Sr. 5 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**√**M 2□ F Months Days Hours Min. Director 215-36-4976 Oct. 16,1940 Maryland Usual Residence of Decedent hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examination routiled at 1 ☐Yes 2XINo Director Baltimore Maryland Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 7919 32nd Street 21237 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married Married 1 ☐ Yes 2XXXNo Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fuel Oil Co. <u> Maintenance Engineer</u> 12\_Years 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Augusta Smith ပ James Earl Dean, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7919 32nd Street Rosedale, Maryland Mrs. Sharon A. Dean (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from Gardens of Faith Cem. 5/27/2008 Rosedale, MD 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Si v ature 22. Name and Address of Facility Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk. Marvland 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) hr Physician Status ASTH maticus /Medical Due to (or as a consequence of): Examiner 10 Asth ma Years Sequentially list conditions, any hading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed physician and the burial-transit disease chronic Luna years Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1∐ Yes 2⊿No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only Medi and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) William andrew Kenne 5-21-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANKLIN SQUARE DR Balto md 21237 Renie DR William Andrew 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sporte Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Ida W. Evans 2008 23 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Levindale Nursing Center Baltimore N/A 3irthpic Country) VA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9 / 26 / 23 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days Year) 84 1 □ M 2 🛛 F 218-22-2181 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show N/A Baltimore 1 XYes 2 No MD ral", or items 23a or 28a-f sh Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 2554 McCulloh Street 21217 USA Funeral death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, eAfrican Pages 1 and 2 should be filed within 72 hours after 1 Yes M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify.American 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Completed by 3 Novidowed 4 Divorced "natural" 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Dorsey John Henry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendell Evans/Son 1555 Unionport Rd, Bronx, NY 10462 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 5/31968 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Baltimore, MD 4 Donation 5 Other (\$pecify) 22. Name and Address of FacilitHari P. Close F.Svs., PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ementia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine pertension that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The law within 24 bours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death Natural Accident 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 28c. Injury at Work? (Month, Day Year) Division 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signatur

State Registrar Debrg Swerthemer no 2939
31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

ORIGINAL

		Please	Type or Prin				_		ible.	
		1 - For State Registrar	State of Ma		partment of I ertificate of			giene Reg. No.?	100	16075
1989	- Ac	Hegistrar     Decedent's Name (First, Middle, Last	st)		orimouto or	Dourn	2. Date of Dea	ath	Von	3. Time of Death
Physi /Med	cian dical	LEON		FLO	URNO	Y	Month MAY	25	Year 2008	8:50 A <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, give		,		or Location of Deat	th	4c. Coun	ty of Death	
Funera	al .	JOHNS HOPKINS—BA 5. Social Security Number 6. S		e (In yrs. last birthd		If Under 24 Hrs			9. Birthpla	ace (State or Foreign
Directo		219-22-8583	M 2□F	81 Yrs	Months Days	Hours Min.	(Month, Day		Countr	<b>MD</b>
and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10-	d. Inside City Limits
Maryl a-f sho fied a	tor	MD BALTIMO	RE	DUNDAL	K					1 <b>X</b> Yes 2□No
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		201042	10f. Zip Code			10g. Citizen o	f What Countr	y?
eath w Is 23a must I	eral	1915 ARMCO WAY  11. Marital Status	12. Was Decedent 8	Ever in U.S. 1	3 Was Decedent of I		Specify Yes or No-		SA ace - Americar	n Indian,
Safter d	Fun	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ N If Yes, Give	No .	3. Was Decedent of I		rto Rican, etc.)	BI	lack, White, et	
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21215-0036 d within 72 hours aff giene. rr than "natural", or the Medical Exami	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(G	cedent's Usual Occu ive kind of work done e. DO NOT use retire	during most of wo	orking	16b. Kind of	Business/Indu	ıstry
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be file tal Hy d othe event,	Be C	17. Father's Name (First, Middle, Last,					me (First, Middle,	Maiden Surna	ame)	
Maryland od 2 should be file tith and Mental Hy 27 is marked oth traumatic event	2	WILLIAM FLOURNOY  19a. Informant's Name/Relationship (		19h M	ailing Address (Stree		WATKINS	er City or Tow	n State Zin (	Cade)
Ma nd 2 sl alth an 27 is r		ELVA FLOURNOY/WI		1	15 ARMCO W		IMORE, M			
es 1 all of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Damaual fram State		sposition (Name of crematory or other pla	ace)	Date	20c. Location	n - City or Tow	vn, State
Baltimore, Dermit. Pages 1 a Department of Hes Important: If item any injury or othe		4 Donation 5 ☐ Other (Specif	y)	CROWNS	VILLE VET.		29-08		NSVILLE	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Olice	21. Signature of Funeral Service Licer	. Mart	on	22. Name and Address 1701–31	ess of Facility J		MORTON TIMORE		F.H.,INC 21217
		23a. Part Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory a	rest,	1	Approximate Interval Between Onset and Death
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ords equires en sign	ed by	HYPERT	ENSION				1 🗆 '	res 2□ No	3 ☐ Proba	ably 4 ☑Unknown
<b>Recc</b> e taw re has be je 2 shc	Completed						24a. Was	osy	prior to com	sy findings available upletion of cause of
Vital Rician: The certificate Prector, page							1  Yes	rmed? 2 No	death? 1 ☐ Yes 2	2 □ No
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	State	ROSHELUE 31. Date filed (Month, Day, Year)	SECKULT 32. Figistr	7 600 I	Y WOLF	EALKE	EFF BA	6117	IURE	21287
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	h the Maryland r 28a-f show r notified at
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Maryland 2	12 should be filed h and Mental Hyg r is marked othe traumatic event,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at
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ivision or Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed ter death.  Virector: After this certificate has been signed by the attending physician and not the funeral director, page 2 should be detached for use as the burial-transit

			1 - State Registrar		Certificate of Death				Reg. No. 2008 16977							
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	/Medic		ROGER M FR	AZIER						٧	May	23			11:45	)   M
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New York		\$ J.	UNION MEMORIAL HOS		//	- 4 / 2 / 4 / 2	BAL!	rimol	RE If Under 2	24 Hm T o	D-4/ Di-			I/A	I (Q1-1-	
	Funeral Director		5. Social Security Number 6. Sex 1%0 097-56-8961 Usual Residence of Decedent	KM 2□F	, ,	ast birthday) 45 Yrs.	Months	Days	Hours	Min.	Date of Bir (Month, Da )CT . 1	ay, Yea.	r)	Coun	lace (State of try) H CARC	_
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	or 282	Director	10e. Street and Number				10f. Zip					10g. C	itizen of Wha	at Coun	itry?	
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5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1XXvever Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 <b>X</b> XV If Yes, Give Year or Dates:	lo		1 □ Yes 2	<b>X</b> No	Specify:			11 /2- TAC	Specify:	BLAG	ЗК	
- - - -	within 72 hc ene. than "natui he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	()	(Give	dent's Usual kind of work DO NOT use	k done di	uring most	of working		16b.	Kind of Busir	ness/Ind	dustry	
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O. BOX	death c e attend d for us	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ∐ Fetal	ldeath 3∟	Ectopic pre Other <i>(spe</i>					3)	23d. Date o			Year
Γ	requires that the een signed by the	۵.	Part II. Other significant conditions con	tributing to death bu	ıt not resu	ılting in the ur	nderlying ca	use give	n in Part I.		23e. Did	tobacco	use contribu	ute to th	ne cause of	death?
S	quires n sigr ald be	d by									1 🗆	Yes	2□ No 3	☐ Prob	ably 4 🖻	Unknown
Hecords	law rei as bee 2 shoi	Completed									24a. Was		24b. We	ere auto	psy findings mpletion of c	available
	The late ha	mo									auto perfo 1□ Yes	psy ormed? 2	r dea	ath?	mpietion of c 2 ☐ No	cause of
VII	ysician: The law lis certificate has t director, page 2 s	Be C	25. Was case referred to medical examiner?						26. Place	of Death (	Check only	-				
	> .07 0	To	1 Yes 2 No	ospital: 1 Inpatier		ER/Outpatien			4 L Nui				6 □Other		y)	
	ing P	iio	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury		Bc. Injury Work			d. Describe	how inj	ury occurred	j		
<u>s</u>	ttend death.	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injur	n/ - At ho	me farm etr	M eet factory		'es 2□N		Longtion /	Ctrant	and Number	or Pur	i Pauta Nuu	mhar
DIVISION	al or A s after al Direct	Certification:	4 ☐ Homicide determined	building, etc.	. (Specify	<i>')</i>	cot, lactory,	, onice		20	City or To	wn, Sta	te)	oi nuia	i noute ivai	riber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best oner: On the basis of and manner state	examinat	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, an	d due to the at the time	cause , date a	s) and mann nd place, an	er as s d due to	tated. the cause(	(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c.	29c. License number 29d. Date signed (Month, Day, Year)								
)			Marths	20			AT	24	389	46 -1	HZ	Ma	y 23	, 2	008	
	5		30. Name and address of person who co				Print)									

State

Registrar

31. Date filed (Month, Day, Year)

MAY 27 2008

		1 - State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Cei	rtificate	of L	Death			Reg. No.	800	16	971
3		Decedent's Name (First, Middle	, Last)							Date of De Month	ath Day	Year		of Death
Physi- /Med		WILLIE	FARMER	JR.						5	25	2008		OOAN
Exam		4a. Facility Name (If not institution	give street and numb	per)		4b. City, 7	own, or	Location of Dea	ath			ounty of Death		
		FRANKLIN SQUAR	e HOSPITAL	cente	er			If Under 24 Hr	- I o	D		aLTIN		
Funera Directo		5. Social Security Number 218-78-9851	6. Sex 7.	. Age (In yrs. las		Months	Days	Hours Mir	٦.	Date of Bir (Month, Da JL . 1	th ly, Year) 2 195	Cot	iplace (State intry) RYLAND	· ·
and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limit
Maryli f sho ied at	ō	MADVIAND DAT	TIMORE			ESSEX							1 □ Y	es 2KK
the 1 28a- notifi	Director	MARYLAND BAL	LIMORE			10f. Zip	Code				10g. Citize	en of What Cou	intry?	
3a or		1209 SUGARW	OOD CIRCLE				2122	1			IJ	.S.A.		
death ms 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.			spanic Origin? ( n, Mexican, Pue	Specify	Yes or No		I. Race - Amer Black, White		
be flied within 72 hours after death with the Maryland hall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 □ Never Married 2 X Marri		<b>X</b> No		1 ☐ Yes 2			SITO I TICE	an, etc.)		Specify: BL		
ural";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:										
d within 72 hours aff giene. er than "natural", or the Medical Examl	lete	15. Decedent (Specify only highes			(Give	dent's Usua kind of wor DO NOT us	k done d	turing most of w	orking		160. Kind	d of Business/I	naustry	
within iene.	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4	for 5+)		STRUC'		,			S	ELF		
filed Hygin		17. Father's Name (First, Middle,	Last)			221100		18. Mother's N	ame (Fi	irst, Middle				
nd 2 should be file lith and Mental Hy 27 is marked oth	To Be	WILLIE FARMER	SR.					BA	RBAI	RA LO	NG			
shou and N mar	-	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Number or i	Rural R	oute Numb	er, City or	Town, State, Z	ip Code)	
		Charlene Farme	r/Wife					., Balt	imo	re, M	aryla	nd 2122	21	
ges 1 a t of Hea If Item or othe		20a. Method of Disposition 1    Burial 2 □ Cremation	3 □ Removal from St	cor	ce of Disponence of the contract of the contra	osition (Nam matory or of	e of ther plac	e)	Date	•	20c. Loca	ation - City or	Fown, State	
mit. Pages 1 a partment of Heap portant; if Item		4 □ Donation 5 □ Other (S				L CEM						IMORE,		
permit. Pag Department Important: I any Injury o	2	21. Sign were of Funeral Service	Licensee		2: W	2. Name and ILLIAI	d Addres M C	s of Facility BROWN C	OMMU	YTINU	FUNE	RAL HON	ME P.A	٠.
1 20E 8 6		pawara C	Down					RTH_AVE						
	l.,	23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on eac	ch line.							rrest,		Approxin Interval I Onset ar	nate Between nd Death
Physician	_	Immediate Cause (Final disease or condition resulting in death)	a. Acui	Te Re	SPI	'a Tor	4 1	-ailui	1					da
/Medica Examine	_	resulting in deathy	Due to (or	TE Re rasa conseque - STag	ence of):			1.520						
	■.	Sequentially list conditions,	b. End	- STa q	nee ofk	Live	Α	VI 250	2 5					
nsit / M te	ijĒ	il any, leading to infinediate cause. Enter Underlying Cause (Disease or injury												
execu	Examine	that initiated events resulting in death) Last	Due to (or	r as a conseque	ence of):									
flicate be executed g physician and			d											
= 0,60	Medical										- 1			
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome pf pregnand th 2 □ Fetal o		□Ectopic pr	egnancy				23	Bd. Date of deli Month		Year
ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of dea		Other (sp						MOHIII	Day	Teal
The law requires that the death ce the has been signed by the attendi age 2 should be detached for use	Physician/	9 Unknown Part II. Other significant condition	and contributing to dog	ath but not recult	ing in the u	andorlying of	uso div	on in Part I		23e Did	tohacco us	e contribute to	the cause	of death?
ires that	þ	Fait ii. Other significant condition	one contributing to dea	tii put not result	ang ar the c	indenying ca	ause give	en in Faiti.				/	obably 4	
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has the law	mple				·				-	24a. Was		24b. Were au prior to death?	completion of	gs availa of cause o
		05 W (								1∐ Yes	2 1 No	1 ☐ Yes	2 No	
VILA sician: certifica irector,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hoppital:	patient 2∏E	P/Outpatio	nt 3□ DO	Oth	26. Place of D				□Other (Spe	miffe al	-
JOVISION OF VICE DECORDS, if or Attending Physician: The law requires t after death.  I Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	2	27. Manner of Death	28a. Date of	Injury 2	28b. Time o		8c. Injur Worl				how injury		эну)	
ding fth. : After	tior	1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investi	9	, Day Year)	Injury	М		k? Yes 2 □ No						
or Attend after death Director:	ifica	3 Suicide 6 Could determ	ined 28e. Place o	of injury - At hom		reet, factory	, office		28f.		(Street and wn, State)	Number or Ru	ıral Route N	lumber,
s affer al Direction by	Certification:	4 [Trofflicide	building	g, etc. (Specify)						City of To	wii, State)			
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifice completely filled in by the funeral director,	Medical (		g Physician: To the b Examiner: On the bas	sis of examination										se(s)
thin 2	Med	29b. Signature and title of certifie	and manne	er stated.		290	. Licens	e number			29d. Date	signed (Mont	h, Day, Yea	r)
F 3 F 8				VASILI	(ADD)	MD.	no	00647	-60			122/05		
0		30. Name and address of person	who completed cause								-/	1-0		
7		DR MINUS Vasi		9000 I			Sc	quare	0	R 13	aLTo	md	212	37
	tate	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signatu	ire				<u> </u>	. , ,				
Regi		MAY 27	2008	w K	A	LE)								
DHMH 17 Rev	/2001		1-44		17	The state of								

	•	1 - State Of IVI		ertificate of Death		eg. No.	1697
Physicia	n	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Day Year	3. Time of Death
/Medica	al	James E. Ford Sr.				22, 2008	1:10 P M
Examine	er	4a. Facility Name (If not institution, give street and number) 2853 Plainfield Rd.		4b. City, Town, or Location of Death  Dundalk	1	4c. County of Dea	
Funeral Director		219 12 5815 <sup>1</sup> ⋈ м 2□F	ge (In yrs. last birthda) 82 Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Sept. 1	, Year) 9. Bi , 1925 Ma:	rthplace (State or Foreigi country) ryland
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or I	ocation	* ****		10d. Inside City Limits
Mary a-f sh ffied a	ţċ	Maryland Baltimore	Dur	ndalk			1 □ Yes 2 <b>□</b> ••••••••••••••••••••••••••••••••••••
vith the	Funeral Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What C	ountry?
eath w	era	2853 Plainfield Rd.  11. Marital Status 12. Was Decedent	Ever in II S 13	21222	necify Ves or No-	USA 14. Race - Am	erican Indian.
urs a	2	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent 17. Was Pecedent 18. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent 19. Was Decedent	No	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, Wh	ite, etc.
72 ho 72 ho 72 ho 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	king (	16b. Kind of Business	s/Industry
within sne.	ם	Elementary/Secondary (0-12) College (1-4or	5+)	po NOT use retired) uperintendant		Utiliti	es
filed Hygid	မှိ မျ	12 17. Father's Name ( <i>First, Middle, Last</i> )		*	ne (First, Middle, i	Maiden Surname)	
uld be Vienta rrked rtic ev	면 일	Edward Augustus Ford		Maude L	ee Rober	tson	
and 2 sho salth and 1 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Roland John Ford (Son)	I .	ling Address ( <i>Street and Number or Ru</i> 3 Plainfield Rd. B		-	
or oth		20a. Method of Disposition 1   Burial 2 □Cremation 3 □Removal from State		rematory or other place)		20c. Location - City o	
t. Pag rtmeni rtant:		4 Donation 5 Other (Specify)	HOLLY Hi.	11 Mem. Gardens 5/27	7/2008   E	Baltimore,	Maryland
Depa Depa Impo any la		21. Signature of Funeral Service Licensee	.   H	22. Name and Address of Facility Bruzdzinski Funera	1 Home P	.A.	~~~ 21 221
2032		23a Par 1. Enter the disease, or complications that cause stock, or heart failure. List only one cause on each I	d the death. Do not e	1407 Old Fastern Anter the mode of dying, such as cardiac			Approximate Interval Between
Physician				MYELDMA			Onset and Death
/Medical Examiner			a consequence of):				
	<u>ت</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):				
outed ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c					
tificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as	a consequence of):				
physic the b	edical	d				V to to be to .	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of do Month	elivery Day Year
s that ned by		Part II. Other significant conditions contributing to death t	out not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
equire en sig ould b	ed b	CORONARY ARTERY	DISE	445	1 □ Y	es 2 No 3 □ F	Probably 4 Unknow
e law r as be e 2 sh	Completed by	DIABETIC NEPHR	OPATHY		24a. Was a	sy prior to	autopsy findings available completion of cause of
n: The flicate		OF W.	/	***		2 <b>X</b> No 1 □ Ye	
/sicial	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpati	Othor	ith <i>(Check only or</i>	<i>ence</i> 6 ∐Other <i>(Sp</i>	acity)
nding Phy uth. r: After thi e funeral o	- 1	27. Manner of Death  1 ☑ Natural 5 ☐ Pending (Month, Death of Injection) 2 ☐ Accident investigation	ury 28b. Time	of 28c. Injury at	1	ow injury occurred	ecny)
al or Atte s after des al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of in building, e	jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office	28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
ne Hospit 24 hours ne Funera	Medical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best 2 ★ Medical Examiner: On the basis of and manner stand manner s	of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the durred at the time, o	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
To the To the Committee	Š	29b. Signature and title of cortifier	)	29c. License number	2	29d. Date signed (Mor	
		Maximaniam,	r MO)	DE015022		May 23, 2	008
1541		30. Name and address / person who completed cause of Dr. Teodulo J. Paglinauan M			timoro	Marviland	01 221
Stat		31. Date filed (Month, Day, Year) 32. gist	rar's Signature		CTHOLE!	retarance	21221
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 00 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year **Physician** 2008 VIRGINIA GARRISON MAY 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RUXTON AT MANOR CARE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2CXF 910° Director 229-03-8043 VIRGINIA APR. 8 1918 Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director OWINGS MILLS MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 U.S.A. 4212 PINEFIELD CT. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any Injury or other reaumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) LONDON FOG SEAMSTRESS 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SALLIE BROWN SAMUEL HUBBARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4212 Pinefield Ct., Owings MIlls, Md. 21133 <u>Delores Garr</u>ison/Daughter in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dop fion 5 □ Other (Specify) KING MEMORIAL PARK 05-30-08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Darbara WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC DAY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse wence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 X No P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059 30. Name and address of person who completed cause of seath (Item 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 2 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Edward  $2^{Day}$ 2008 Hilker 5:00P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris</u> Timonium Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 17 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 □ F 219-28-7186 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 □Yes 2√ No Baltimore Maryland Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2510 Gray Manor Terrace 21222 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1x Never Married 2 ☐ Married 1 ☐Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 NA Laborer Coat Hangar Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hilker William Pacuta Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Anna Lotsey</u> <u>(Sister</u> <u>2510 Gray Manor Terrace Dundalk, Maryland 21222</u> 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 24, 2008 Crematory Inc. Baltimore, Maryland 22. Name and Address of Facility
W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service Licenses 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Pat 1. E her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause or each line.

Immediate lause (Final disease or condition resulting in death)

a. DIMENTIA

Due to (or as a consequence of): Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2X No 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nx any injury or other traumatic event, Irs Mexit once.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

and

Examine

Physician/Medical

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Completed

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Certification: To

Medical

ERNESTINE WRIGHT

31. Date filed (Month, Day, Year)

atter death

Director:
d in by the f

P.O. Box 68760 Records, Vital Hospital or Attending Physician: Division of 24 hours a completely filled To the within 2

25. Was case referred to medical examiner? Other:  ${}_{4} \square$  Nursing Home  ${}_{5} \square$  Residence  ${}_{6} X \square$  Other (Specify) **HOSPICE** 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

State Registrar

DHMH 17 Rev 1/2001

2300 DULANEY VALLEY RD.

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien () [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death PAULINE M. HARRIS Month A **Physician** 09,00AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 F Days Months 95 Director 218-14-0278 MD 2/19/1913 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 8337 Montgomery Run Rd Unit D United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify Specify: 2 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George K. Harden Clara Cavey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 Shirley M. Rest/Daughter 8337 Montgomery Run Rd Unit D Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-2008 | Hanover, MD Ardent Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTILOBAR PN GUM ON/A **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran-Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ XACERBATION OF CHROMC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State Registrar 4 Homicide

Kamarwans 31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

Harrang 32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30 Name and address of person who completed cause of death (Item 23a) (Type Print)

1 ☐ Yes 2 ☐ No

DS4288

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

	1		For State of Maryland / Department of State of Maryland / Department of State Registrar  1. Decedent's Name (First, Middle, Last)			Reg. No.	J 8	1 6 9 8 3
	Physici /Medi		Concetta Ilardo		May 24	Day 2008	Year	3:05 am M
	Examir Funeral Director	ner	Heritage Nursing Center  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1 Y Months Direction Month		8. Date of Birt	v. Year)	more 9. Birthp Coul	place (State or Foreig
			217–68–0141 98 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		9/7/19	09		rland  10d. Inside City Limits
	the Marylan 28a-f show notified at	Director	Maryland Baltimore  10e. Street and Number 10f. Zip Co.	nde.		10g. Citizen of	What Cour	1 □Yes 2 X No
	eath with	Funeral Di	155 Grundy Street 2122	4		U. S.	Α.	can Indian,
920	urs after death with the Mar al", or Items 23a or 28a-f st Examiner must be notified	by	Armed Forces?  1 Never Married 2 Married In Yes 2 Mon If Yes, Give Year or Dates:  Armed Forces?  If Yes, specify  1 Yes 2 Mon If Yes, Give Year or Dates:	t of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	to Rican, etc.)	Blac Specif	ck, White,	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual O (Give kind of work of life. DO NOT use re	lone during most of wo.	rking	16b. Kind of B		
ind 21	be filed watal Hygier of other the event, the	Be	6 Homemaker  17. Father's Name (First, Middle, Last)	18. Mother's Nai	me (First, Middle,	Own Ho		
Aaryla	2 should and Mer is marke raumatic	오	Vincenzo Marzullo  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (St.	Rosa treet and Number or Ri	Serio Jural Route Numbe	er, City or Town,	State, Zip	Code)
Baltimore, 1	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		Connie Helen Carbone (neice) 850 Sue Gro  20a. Method of Disposition  Will Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Connie Helen Carbone (neice) 850 Sue Gro  20b. Place of Disposition (Name of Cemetery, Crematory or other  Most Holy Redeen	of r place)	Essex, Ma Date 5/28 2008	20c. Location	· City or To	21 own, State Maryland
Balti	permit. Departm Importa any inju		21. Signature of Eureral Service Ucensee 22. Name and Al VBruzdz	ddress of Facility inski Fune d Eastern	ral Home	PΔ		-
	Example of physician and burysician and as the burial-transit	ledical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Figure that initiated events resulting in death) Last  ATHERS SCLE ROTION Due to (or as a consequence of):  Due to (or as a consequence of):  C. JIEOPOROSIS  Due to (or as a consequence of):  C. HRONIC ICIDNEY			ILAK D	I ISEM.	SE
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (specification)				te of delive	ery Day Year
rds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.		obacco use cont ⁄es 2 □ No		he cause of death?
Il Reco	The law re cate has bee page 2 sho	Completed				rmed?	prior to co death?	opsy findings available impletion of cause of 2 No
r Vita	hysiclan his certifii I director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Othor	ath <i>(Check only o</i> Home 5□ Resid	_	ner (Specif	fy)
=	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Certification:		Injury at Work? 1 ☐ Yes 2 ☐ No ffice	28d. Describe h	Street and Numb		al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the desired of the basis of examination and/or investigation, in and manner stated.	ne time, date and place my opinion, death occ	e, and due to the curred at the time,	cause(s) and made, date and place,	anner as s and due t	stated. to the cause(s)
	To t To t	Ň	29b. Signature and title of certifier  Sandel (Tulke M)  29c. Lie	27188	2	29d. Date signe	d ( <i>Month</i> ,	Day, Year)
	\		Sander (Tulle M)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Sander (CTulle 2 Markel P)	Vace Du	udalk	MO	21	222
	Sta Registr	- 1	31. Date filed (Month, Day, Year)  MAY 2 7 2008  32 Tegistrar's Signature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22<sup>Day</sup> **Physician** 2008 9:15A **ISNER** CLARA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 2417 TANEY ROAD BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) CEDMANN 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth 6 Sex **Funeral** 0671271914 Months Days Hours Min 1 □ M 2 🕱 F **GERMANY** 119-16-3777 93 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show th and Mental Hygiene. 7 Is marked other than "natural", or frems 23a or 28a-f shov traumatic event, the Medical Examber must be notified at 1X Yes 2 □ No Director N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 21215 USA 6101 PARK HEIGHTS AVENUE, #2-H Funeral Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 🛣 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHAN WOLF **GERTRUDE** SIMON မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau 2417 TANEY ROAD, BALTIMORE, MD LYNN GLAZER / DAUGHTER 20b. Place of Disposition (Name of complete Complete PARK Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 05/23/2008 CLIFTON, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIODULARUM Muediata /Medical Due to (or as consequence **Examiner** heart Means Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bue to (or as a consequence of) law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown cate has been si page 2 should b 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specification) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2/ Accident investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and

complete

trucke

MA

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BALT.

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departm		lental Hygi	ene	
	_		Registrar CET (III)	cate of Death	2. Date of Death	g. No. 2. 0. 0. 8	16935
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Month	22 2008	3. Time of Death 8:41 a M
1	/Medic		George Jenkins  4a. Facility Name (If not institution, give street and number)  4b.	City, Town, or Location of Death	<u> </u>	4c. County of Death	
	Examin	er		owson		Balto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Inder 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign
	Director		416-34-7333 X M 2 F 80 Yrs. Mol	nths Days Hours Min.	4-14	-1928	AL
	put &		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	faryla r sho	or		,			1. Yes 2 No
	28a-	Director	MD N/A Baltimore	f. Zip Code	10	g. Citizen of What Cou	Λ
	3a or	Ē	1702 N. Milton Avenue	21213		USA	
	death	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was D	Decedent of Hispanic Origin? (Spe, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
98	after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	es 2 No Specify:	nican, etc.)	Black, White	
21215-0036	72 hours after death with the Maryland tratural", or items 23a or 28a-f show dical Evanding and be notified at	d by	3 L Widowed 4 □ Divorced Year or Dates:	••		ŀ	Black
15	n 72 r "nat	olete	15. Decedent's Education (Specify only highest grade completed) (Give kind of life, DO N)	Usual Occupation of work done during most of working OT use retired)	ng unk '	6b. Kind of Business/!	unk unk
212	withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  8th grade N/A				
פַ	al Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	aiden Surname)	
/lar	uld by Menta arked atic ev	To E	John Jenkins	Carrie	e Smith		
Maryland	2 sho and is ma rauma	. 19	19a. Informant's Name/Relationship (Type. Print)	dress (Street and Number or Rura	_		
<u>ه</u>	and dealth im 27 ther to			Lyndale Avenu		to, MD 2	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, he second Event and the public of once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crematory			0c. Location - City or T	
Ē	artme artme ortant Injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  Arbutus M  22. Nar			Arbutus, /H East	ממ
Ba	Depar Impo any Ir			1 E. North Av		7 ( //	21202
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the				Approximate Interval Between
Sic.	Physician	1	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	4,00			Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	ditense			100
	Examiner		Sequentially list conditions, b. Colony afterly	disease		200	Gens
	Da / / to	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury				)
	and all-tran	xan	that initiated events resulting in death) Last   Due to (or as a consequence of):				
68760,	tificate be executed g physician and as the burial-transit						
89	tificating phy as the	ledical	0.				
Вох	eath certifi attending for use as	J.	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ecto	opic pregnancy		23d. Date of deli	very
<u>.</u>	e dear	Physician/M	in the past 12 months?  1	er (specify)		Month	Day Year
P. O.	d by t	Phy	9 Unknown	in a superior in Post I	22a Did tob	anna una contributa ta	the source of death?
ds,	ires th signe I be d	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part i.		acco use contribute to s 2 ☐ No 3 ☐ Pro	N .
Ö	requ	Completed					71
Rec	has ge 2 a	d m			24a. Was an autopsy perform	prior to c ed? death?	topsy findings available completion of cause of
ā	n: Th		25. Was case referred to medical	00 81(8	1 □Yes 2	Down 1 ☐ Yes	2 🗆 No
>	ysicia s cert directu	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death		nce 6 Other (Spec	DIDE ON WAR
ס ר	ding Physician: The h. After this certificate h funeral director, page	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		3.119)
<u>i</u>	endin sath. or: Af he fur	atio	2 Accident investigation M				
Division of Vital Records,	or Att ter de irecto n by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Ω	pital o		29a. Certifier Certifying Physician: To the best of my knowledge, death occi				
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after feet.  Within 24 hours after feet.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, death occur (Check only one) Medical Examiner: On the basis of examination and/or investig and manner stated.	ation, in my opinion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	i, Day, Year)
			Man m	0) 58303	M	144 37.	1-000
	h		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29c License aumber 58303	N MA	2,204	
	J		AMON J. CHANGES VID GUI IV, CUM	uct 01 /000 300	V (00)	- /	
	Stat Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shirley J. Johnson Month Year 05:26 PM May 70 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1□ M **X**XF 75 212-30-8614 April 11,1933 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits MD 1 ∏Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 W. University Pkwy Apt 1425 21210 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2000 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

COOK 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Greenspring Inn 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grandville Chelton Ethel Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Johnson (Son) 8458 Geneva Rd. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial ACremation 3 ☐ Removal from State Metro Crematory 5/23/8 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3637 Falls Road Balto, MD 2121 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest 2 weeks Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Ischemic Colitis Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4□Pregnant at time of death Day 5 ☐ Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1/X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury

Physician /Medical Examiner The law requires that the death certificate be executed and

attending physician for use as the buria

the

certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this continued.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

a or 28a-f show be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 3 any injury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner Physician/Medical þ Completed Be

Division or Vital Records, P.O. Box 68760, ←

Certification: To

Medical

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

Preston

31. Date filed (Month, Day,

6 Could not be determined

P. Jones

Jones

Year) 7 2008

3) Firme and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

State Registrar

h

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

at 2438946-HZ8

Union Memorial Hospital Baltimore, MD

1 5 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion double course.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 20, 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 8:274M Mildred L. Jackson 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Hos altimore meneral If Under 1 Year If Under Date of Birth (Month, Day, Year) Birthplace (State or Foreign Gountry) **Funeral** Days Min. 1 □ M 2 □ F Months Hours Director 214-44-6425 Apr 30, 1945 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 1 Nes 2 No be notified Director **Baltimore** N/A Marvland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 2601 Spellman Road 21225 U.S.A. 'natural", or items 23a Funeral traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☐ No Specify: ò Specify. Black 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker h and Mental Hygie 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carry Graham Matthew Graham 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau 2601 Spellman Road Baltimore, Maryland 21225 Evelyn Hinton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Rurial 2 ☐ Cremation 3 ☐ Removal from State 05/21/08 Lansdowne, Maryland 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery permit. 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician perkalemia disease or condition resulting in death) /Medical Du f (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or mijury that initiated events Examiner sician and burial-transit nronic resulting in death) Last Due to (or as a consequence of): Physician/Medical nding physiuse as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery atten for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 Yes 2 No 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1∏ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Other: 4 \sum Nursing Home Hospital: 3□ DOA 1 ☐ Yes 2 7 No 1 Ampatient 2 ER/Outpatient Certification: To 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 2 🗆 No 1 Tyes within 24 hours after death. To the Funeral Director: / completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

The law requires that the death certificate be executed P.0. or Vital Records, Physician: Division or Attending To the Hospital o within 24 hours aft To the Funeral Di

Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

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(Check only one)

29b. Signature and tifle of certifier

Jorawar 31. Date filed (Month, Day,

Quoll

30. Name and address of person who completed cause of

Year)

death (Item 23a) (Type, Print)

0/0

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 Year Physician 23, May 5:20 P M Philip Charles Kogler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 8212 Grainfield Rd Severn 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 212-42-7678 FEB 14, Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location MD 1 ☐ Yes 2 No Anne Arundel Severn permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Imporant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examinar must be 1 citified ance. Funeral Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 8212 Grainfield Rd **USA** 21144 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Fire Fighter Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip G. Kogler Amber C. Silkworth ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8212 Grainfield Rd Severn, MD 21144 Shirley Kogler/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc | 5/24/08 <sup>22, Name and Address of Facility</sup> Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD 21. Signature of Funeral Service Licensee Todd Dring 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Netustah /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be execut attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day 5 ☐ Other (specify) ed by the a detached f signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 □ Yes 2 □ 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation | Natural 1 ☐ Yes 2 ☐ No death. spital or Attendi lours after death. neral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

d address of person who completed cause of death (Item 23a) (Type, Print)

Dennis

Sperk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 05 2008 Abner Kaplan 06:15  $p^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN WIRSING CTR BALTIHORS (100 D N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/1910 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☑ M 2 ☐ F 218-36-9355 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits items 23a or 28a-f shov ner must be notified at 1 ☑ Yes 2 ☐ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2402 Strathmore Avenue 21214 Funeral U.S .A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian r than "natural", or iten the Medical Examiner 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I I 1 ☐ Never Married 2 ☐ Married Honer Kapland Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker State Government If item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Harry Kaplan Annie Schwartz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doug J. Kaplan, Son 2904 Pinewood Avenue, Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corp. 05/27/2008 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. ( Slepandua 5 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMERS DISERSE **Physician** /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AFRTEN SISN 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1∐ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၀ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28150

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

EM ALIE

39. Name and address of person who completed cause of death (Item 23a) (Type, Print) LXAXI



5601 Locut

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7:45 PM Vincent May 22, 2008 Earl Kent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A St. Joseph Manor Baltimore City 911 W. Lake Ave If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 78 06-07-1929 MaryTand 213-28-8261 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ire Medical Evarative must be notified at once. Director Maryland 1 TXYes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 911 W. Lake Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗶 No Specify. \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Brother Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore, Maryland 21202 St. Joseph Society Sacred Heart 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Catherdral Cem. 05/28/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses Baltimore, Maryland Inc. 5305 Harford 21214 Rd. Leonard J. Ruck. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARCINOMA Immediate Cause (Final disease or condition resulting in death) EDATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician the burial Physician/Medical attending p for use as t 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome regnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s certificate 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 ₹ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death.
neral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Tolvy, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number D0034952 29d. Date signed (Month, Day, Year) Evelest M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 600 SUER DRIVE SUITE 308 TOWSON, HARYLAND 21209 2. Registrar's Signature 7 2008 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** KANDEL ROSE 7.35 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTIMORE 8. Date of Birth Month Bay Year) 1 11/09/1911 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days 1 □ M 2 🕽 F Hours Min 96 082-05-3927 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercitive Light and once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 HARRISON AVENUE 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 [Yes 2] If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐ No Specify <u>≨</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **SCHECHTER** MOLLIE BASHEIN MAX ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11776 240 NORWOOD AVENUE, PORT JEFFERSON STATION, NY MICHAEL KANDEL / SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTÍMORE HEBREW 05/23/2008 REISTERSTOWN, MD 4 Donation 5 ☐ Other (Specify) Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signatur 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause of each line. 23a. Part 1. Approximate Interval Between Immediat Cause (Final disease or condition resulting in death) theroscl run'c Cardio Vascular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence on The law requires that the death certificate be executed and buriai-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Type Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

20

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Dr. Taria Mahmood

MAY 2

2300 Dulane

29c. License number

+3725

Valley

29d. Date signed (Month, Day, Year)

Timonium MD 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 16992

011414		I- For State Critificate of Death Registrar	ionian nys		. No.	
Physicia		1. Decedent's Name (First, Middle,Last)	2	. Date of Death	Day Year	3. Time of Death
ledical Exami	ner	Howard John Leary		May 22, 200	08	1621 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location	tion of Death		4c. County of Dear Baltimore Co	
:		1429 Sussex Road Essex		o Data of Blath		
Funeral			Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. B Fore	an
Director		216-76-5932 1X M 2 F 49 Yrs.		1/24/1	959	ountry) Maryland
ě		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
ow any						1 Yes 2 XNo
Maryland 28a-f show d at once.	į	Maryland Baltimore Essex  10e. Street and Number 10f. Zip Code		100	a. Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once.	Director					·
ith th		1 429 Sussex Road 21221  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	c Origin? ( Spe		J. S. A.  14. Race - Ame	rican Indian, Black,
death w or items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mex	xican, Puerto R	tican, etc.)	White, etc.	
her de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No spe	ecify:		Specify: W	hite
nurs af	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Company)			16b. Kind of Business	
72 ho	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO N	NOT use retire	(a)		
036 vithin ene.	E	12 Mechanic			Automoti	ve
5-0 iled v Hygi Joth	ပ				aiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Millard William Leary, Sr. Ro  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	OSE	Ella	Me.L	te Zin Code)
WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ř	,,,,,			land 2122	_
and 2 and 2 lealth tem 2 traum		20a. Method of Disposition 20b. Place of Disposition (Name of cemeter)			20c. Location - City of	
ges l t of H		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	5/2 200	28	Daltimore	Marriand
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5 Other Specify: Bayview Crematory 21. Signature perfuneral Services (Sphee) 22. Name and Address of Fa				, Maryland
Department of the partment of		Bruzdzinski	Funera	11 Home	PA Essex. Ma	ryland 21221
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause of each line.  Immediate Cause (Final disease a. Imraoral gunshot wound				Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):				
	Ļ	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):				-
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		-		1
= = du	xan	events resulting in death) Last Due to (or as a consequence of):				
and - tran		d				
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED			Dod Date of delive	
<b>9</b> # 4 9		IF FEMALE: 23b. Was decedent pregnant in the control 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Economics	ctopic pregnan	су	23d. Date of delive Month	Day Year
Box 687 death certific the attending p	sician	past 12 months?  Pregnant at time of death 5 Other (Specify)			Į.	
Bo e deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown		Loo pitti		the course of death?
ision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certific death.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as it.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.			o the cause of death?  obably 4  Unknown
S, F	ed t			24a. Was a		autopsy findings available
cords, law requii has been s	plet			autops perforr	y prior to	completion of cause of
Rec The Is icate h	Completed		_	1 ✓ Yes 2		
Vital Rec ysician: The his certificate director, page	Be	evaminer?	Death (Check or			
of Vit ing Physic After this	은	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA			Residence 6  Oth	ner: Scene
n of ding Ph	.: ::	27. Manner of Death  28a. Date of Injury  (Month: Day, Year)  1 Natural 5 Pending  28a. Date of Injury  FOUND: 28b. Time of Injury  28c. Injury at V  1 Yes:		Subject shot		
SiO Atten deatl by the	cati	2 Accident Investigation May 22, 2008 1615 hrs 1899 Place of Injury - At home farm street factory office building		28f Location (S	treet and Number or	Rural Route Number, City
Division of Vital Records, real or Attending Physician: The law requirers after death.  al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	determined (Specific) Single Family			ate) Road, Essex, MD	,
lospid 4 hour funer		29a. Certifier 1 Countries Rhysisians. To the heat of my knowledge death occurred at the time date as				ated.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	ath occurred at	the time, date a	nd place, and due to	the cause(s)
- F : F : S	Re	29b. Signature and title of certifier 29c. License nur			29d. Date signed (A	fonth, Day, Year)
		Thedre M K Thy The O.C.M.E	OCME		May 23, 2008	
		30. Name and address of person who completed cause of death (Item 23a)				
5		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street,	t, Baltimore	, MD 21201		
	ate	31. Date filed (Month, Day, Year)  MAY 2, 7 2008  32. Figistrar's Signature				
Regis						
DHMH 17 Rev 1/2	001	ORIĞINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Day Year MAY -851E 03:30 M /Medical 2008 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL Columbia ttowareo 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 97 Hours 156-18-4496 Director 6/23/1910 SC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Director Howard 1 ☐ Yes 2 X No MD Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5233 Farm Pond Lane 21045 USA Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify African 'natural", or Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 □ Widowed 4 □ Divorced American Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important; If Item 27 is marked other the any injury or other traumatic event, the once. Seamstress 12 Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Chambers Ella Garrett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Sommerville/Daughter 5233 Farm Pond Lane, Columbia, MD 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/08 Egg HarborCity, NJ Egg Habor C. Cem. 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Funeral Service Lice 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician umoru disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 17000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tra law requires that the death certificate be execu Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the SS IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death P.O. 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, sign. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this y filled in by the funeral di 28a: Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28d. Describe how injury occurred or Attending 1 D Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated

State Registrar

31. Date filed (Month, Day, Year)

5

29b. Signature and title of certifier



30. Name and address preson who completed cause of death (Item 23a) (Type, Print)

CEDAR

7 2008

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my)

29d. Date signed (Month. Day, Year)

MAY 12 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Voar 104/02 May 11.38AM nnie 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hespital General columbia Howard Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕱 F Hours Director 230-18-6158 02/09/1919 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits MD HOWARD COLUMBIA Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 11250 A CRYSTAL RUN 21044 should be filed within 72 hours after death v nd Mental Hygiene. marked other than "natural". or items 23s USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: BLACK 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER PUBLIC SCHOOL SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil f Health and Mental H item 27 is marked oth Be **JAMES TAYLOR** ပ LOTTIE **JOHNSON** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA PEARSON/DAUGHTER 11250A CRYSTAL RUN, COLUMBIA, MD 21044 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5-30-2008 CREST VIEW CEM SOUTH HILL, VA Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701-31 LAURENS ST. BALTIMORE, MD 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kenal **Physician** Heute 48 hours /Medical Due to (or as a consequence of): Examiner Electrolyte Abnormalilie. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 5 certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending I hours after death. 1 Natural 5 ☐ Pending investigation within 24 hours after deau...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10724 Wille

legistrar's Signat∎re

20060345

Patuexant Parkway Columbia MD 21044

08-03922

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	B	Registrar 2 Date of Death 3. Time of Death						
ledical Examir	ег	Martha A. Monzone May 22, 2008 1456 hrs						
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		Sittal Hospital						
Funeral		Months Days Hours Min. 2 20 1044						
Director		21/-56-7635 1 M 2 AF 0-2 TIS.						
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits						
<b>*</b> .	ě	MD N/A Baltimore 1 X Yes 2 No						
4aryland 28a-f show 1 at once.		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?						
he Ma	흠	2411 Pickering Drive Apt A 21234 U.S.A						
with the Maryland ms 23a or 28a-f sho be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	Never Married 2 Married 1 Yes 2 No						
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136 thin 72 hours after te. than "natural", edical Ex. miner	Ed.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						
136 hin 72 e. than	Completed	Character N/A Chicken Packer Factory						
5-00 led with Hygien other	흥	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)						
21215-0036 ould be filed within 7 Mental Hygiene. I marked other than is event, the Medics	Be	Jell Bemon						
21 bould nd Me is ma ntic ex	유	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  2010 F. Preston Street Balto, MD 21213						
ME ad 2 s alth a m 27		Gloria J. Lemon-Daughter 2010 E. Preston Street Balto, MD 21213  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State						
of He		1 X Burial 2 Cremation 3 Removal from State Arbutus Memorial 5-28-08 Arbutus, MD						
Baltimore, permit Pages I ar Department of Her Important: If ite		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  March F/H East						
Baltimo permit Page Department of Important: injury or oth		M lada 47 amea ) 1101 E. North Avenue Balto, MD 21202						
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate intervals and Retween Onset and						
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease a. Hypertensive Atherosclerotic Cardiovascular Disease						
:aminer		or condition resulting in death)  Due to (or as a consequence of):						
	Sequentially list conditions, If any leading to immediate  Due to (or as a consequence of):							
	Examiner	cause. Enter Underlying Cause						
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Box 6876( c) death certificate the attending phy ed for use as the be	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown  9 Unknown						
D. BC the dea	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?						
, <b>P.O.</b> ires that the signed by		End Stage Renal Disease, Diabetes Mellitus						
ds, equire een si	Completed by	24a. Was an 24b. Were autopsy findings ave autopsy prior to completion of caus						
COF lawr has b	햩	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No						
Re ifficate	ខ	25. Was case referred to medical 26.Place of Death (Check only one)						
/ital	Be G	examiner?  1 Ves 2 No						
Of V ig Phy neral o	<u>و</u>	27. Manner of Death  28a. Date of Injury  (Month. Day, Year)  28b. Time of Injury  28c. Injury at Work?  28d. Describe now injury occurred						
On endin sath. or: A	흝	1 V Natural 5 Pending						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the law free factor. After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Coor Town, State)						
Di spital sours a	9	4 Homicide determined (Specify)						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
To the within To the comp	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						
	٤	O.C.M.E. May 23, 2008						
		30. Name and addr-ss of person who completed cause of death (Item 23a)						
3		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regi	strai							
DHMH 17 Rev 1	2001	OCME ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 28c per me, g879,05/27/08dhb Reg. No. 1 - State Registrar Reg. No.-Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Pr. 2008 10:00 pM Alejandro Moreno /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8 Pate of Birth 8 Path, 9 ay, 96 as 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) Sex. **Funeral** Days Hours Min. Months El Salvador 49 216-96-7298 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at 1 ☐Yes 2 No Director Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number El Salvador 20877 112 Duvall Lane Tl Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Salvadoran White Specify: \$ 3 Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene.

Is marked other than "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Insurance Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zoila Antonia Hernandez Salvador Moreno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important; If item 27 is 1
any injury or other trausonce. 4906 Lincoln Ave. Beltsville, MD 20705 Zoila Quiroa/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 5/21 08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Lice MO0332 Stepl 933 Gist Ave. Silver Spring Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 disease or condition resulting in death) a Sepsis mo /Medical Due to (or as a consequence of): Examiner b. Respiratory Insuff Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed c. Skull\_Fx attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760, Physician/Medical Lymphoma IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. detached 9 Unknown 9 Unknown à s been signed to stood be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed HIV 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an icale has b pge 2 sl autopsy performed? 1 Yes 2 No certificale funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28d. Describe how injury occurred
Found down on floor at home 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? Attending 1 Natural 5 Pendina 1 ☐ Yes 🏖 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 4/17/08 2100 no witness- fall 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number T 1 City or Town, State) 4 Homicide Home Gaithersburg, MD 20877 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 066066 cor pleted cause of death (Item 23a) (Type, Print)

State Registrar

30. Name and address of person wh

31. Date filed (Mon

Inpm

5/15/08

oreno, Alejandro

egistrar's Sidi

8600 Old Georgetown Rd. Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3. Time of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DIMIA 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 MM 2□F Months Hours Min 214-40-995 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Blac 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Mediconce. Elementary/Secondary (0-12) College (1-4or 5+) 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be mma (Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
JOSEPH L. RUSS
2222 W. North 21. Signature of Funeral Service Licenses Part I. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 yeurs CORON ARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Type II Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 XNo 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Declined 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident the Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D062922 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tetu BALTIMORE 10 PLAZA MO 31. Date filed (Month, Day) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Barbara Jane Mann a M May 7:25 24 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Blakehurst Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Vear 1 □ M 2 🔀 F Months Days Hours 85 217-14-4995 18, Maryland 1922 Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 XNo Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 1055 W. Joppa Rd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +4 Elementary/Secondary (0-12) Dietitian Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen McLaughlin Phillip | T. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kay Schuyler/ Daughter 6 Scottsdale Court Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-08 Dulaney Valley Mem. Timonium, Md. 21. Signature of Fuguer I Se wice Vicen e 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) makiner 1cmentea Due to (or as a consequence of): Sequentially list conditions Din'to for as a consequence of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Event, has be with a sonce.

Baltimore, Maryland 21215-0036

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The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

Hospital or Attending

Exami Physician/Medical ģ Completed Be Certification: To

IF FEMALE:

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this certificate After this funeral of To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

∃Yes 9 Unknown

> 2 No 1 ☐ Yes

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death 1 Watural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles ST porson no 21204 CHANGE ATON NI) 6701 J 31. Date filed (Month, Day, Year)

State Registrar

Medical

7 2008

5 Pending

investigation

determined

6 ☐ Could not be



Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28a. Date of Injury (Month, Day, Year)

			1- For amend #19 Per FH 6879 5/28/0	Depa Jiji Cer	rtment of He	alth and M eath	lental Hygie	ene	8 15999	
	Physici		Decedent's Name (First, Middle, Last)     BERNIECE IRENE McMULLAN				2. Date of Death Month	Day Yea		
1	/Medic Examir		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		MAY	4c. County of Death None			
	Funeral	, já	5. Social Security Number 6. Sex 7. Age (In yrs. last 502–09–3072 1 M 2/XF 93	birthday)_ Yrs.	If Under 1 Year   I	f Under 24 Hrs.	8. Date of Birth (Month, Day, Y April 21	0.5	sirthplace (State or Foreign Country) orth Dakota	
	Director		Usual Residence of Decedent  10a. State 10b. County 10c. City, T		ation		April 21	, 1915   NC		
036	Maryla I-f shov fied at	Se Completed by Funeral Direct		imore					10d. Inside City Limits 1√√Yes 2 No	
	or 28a		10e. Street and Number	1111010	10f. Zip Code		10g	. Citizen of What	1111	
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at		610 West 40th Street  11. Marital Status  12. Was Decedent Ever in U.S.	13. V	2121 Vas Decedent of Hisp		ecify Yes or No-	USA 14. Race - Ar	nerican Indian,	
			1 Never Married 2 Married  **Married 2 Married A Divorced Sear or Dates:	-	Vas Decedent of Hisp i Yes, specify Cuban, ☐ Yes XX No	Mexican, Puerto  Specify:	Rican, etc.)	Black, W	nite, etc.	
215-0036	be filed within 72 hortal Hygiene. dother than "naturevent, the Medical		(Specify only highest grade completed)	6a. Deced (Give I	ent's Usual Occupation  kind of work done dur  OO NOT use retired)	on ing most of worki	ng 16	6b. Kind of Busines	ss/Industry	
21	filed within Hygiene. ther than "		Elementary/Secondary (0-12) College (1-4or 5+) 4		Financial			Finan	ce	
Maryland			17. Father's Name (First, Middle, Last) Andor Anderson		18		<i>(First, Middle, Ma</i> da Tanger	,		
lary	and sand		19a. Informant's Name Memor hearinge. Print)		g Address (Street and	d Number or Rura	al Route Number, (	——————————————————————————————————————		
	Health Health tem 27				est 40th S sition (Name of natory or other place)			Marylan  C. Location - City		
Baltimore,	Pages 1 and ment of Health ant: If Item 27 iury or other t		1 ☐ Burial XXCremation 3 ☐ Removal from State Greel	<sub>etery, ciem</sub> nMoun	natorý or other place) t Cremator	y May 2				
Balt	permit. Pages Department of Important: If It any injury or o		21. A nature of Funeral Sovice Licensee	22.					neral Home In and 21212	
98	Physician /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying,	such as cardiac c	r respiratory arres	t,	Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)							
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			Sequentially list conditions, if any keding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	the body						
60,	ficate be executed physician and sthe burial-transit		resulting in death) Last Due to (or as a consequent	nce of):						
68760,	tificate g phys as the	edical	d							
.O. Box	Physician: The law requires that the death certificate this certificate has been signed by the attending trail director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 S No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year	
Δ.			Part II. Other significant conditions contributing to death but not resultin	_				cco use contribute	to the cause of death?	
Sord			COAGULOPATHY SEC.						Probably 4 Unknown	
Division or Vital Records,			CUARULOPATAY SEC.	10 (	CO UNIX	DIM	24a. Was an autopsy performe	prior t		
Vita			25. Was case referred to medical examiner?  Hospital: Hospital:				(Check only one)			
J Or	ding Physician:  After this certific funeral director,		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							
isioi	ttendin death. stor: Af the fur		2 Accident investigation 3 Suicide 6 Could not be		M 1 □ Yes 2 □ No					
Di	tal or A s after al Direct ed in b)	Certif	4 Homicide determined building, etc. (Specify)	ce of injury - At home, farm, street, factory, office lding, etc. (Specify)			City or Town,	Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier (Check only one)  1	dge, death and/or inv	occurred at the time, estigation, in my opin	date and place, a lion, death occurr	and due to the cau ed at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)	
			29b. Signature and the of certifier  29 Viller mana M1		29c. License n			Date signed (Mo		
	1 0		30. Name and address of person who completed cause of death (Item 23.	a) (Type, P	Print) UN	7/23	EMARIA	1 HA.C	25,2008	
2	6		JUSEPH PULLANA 2	COIE	-unv	PKWY,	BALTI	MORE	MD 21218	
4	Sta Registra	- 4	31. Date filed (Month, Day, Year)  MAY 2 7 2008  . Registrar's Signature	Span	W					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 10 11A M Lois A. Morrison 2008 Mai /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltim Hospital Sinau N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Sex Date of Birth (Month, Day, Year) Nov 21, 1938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 👿 F Alabama Director 69 419-56-5087 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location a or 28a-f show t be notified at 10d. Inside City Limits 1 Yes 2 No Director Baltimore Marvland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21215 4905 Reisterstown Road items 23a must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, "natural", or items ledical Examiner m Black, White, etc. I ☐ Yes 2 ☐ ★ No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ ★ Married 1 ☐ Yes 2 ☐ Xio Specify. Black Specify. 3 ☐ Widowed 4 ☐ Divorced er than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Private College (1-4or 5+) Nurse Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Annetta Lewis Samuel Lewis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau 4905 Reisterstown Road Baltimore, Maryland 21215 Gary Morrison 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Murial 2 ■ Cremation 3 ■ Removal from State 05/21/08 Lansdowne, Maryland Mt. Zion Cemetery 4 Donation 5 Other (Specify) 21. Signature of Pineral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 allen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat immediate Cause (Final disease or condition resulting in death) **Physician** ardiac 40 mb /Medical Due to (or as a conseduence of) Examiner besteusen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a conse tuence of the Vocal cord ana woma sician and burial-tran certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months? Dav Year 4□Pregnant at time of death 5 Other (specify) the detached 9 I Inknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No autopsy performed? certificate 2 No 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Man r of Death after death. I Director: After the d in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending within 24 hours a

To the Funeral C

> State Registrar

IARIQ 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

KHAD 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WO

29c. License number

D0081730

29d. Date signed (Month, Day, Year)

8008